Perceptions of culturally competent practice behaviour by newly qualified nurses

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Abstract

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Keywords

Cultural Competence, Newly Qualified Nurses, Nursing Behaviour, Nursing Practice, Transition

Background: The nursing workforce needs to be adequately prepared to deliver care to an increasingly diverse patient population in the United Kingdom (UK). The Nursing and Midwifery Council (NMC) expects newly qualified nurses (NQNs) to deliver culturally sensitive and respectful care.

Aim: The study aimed to explore NQNs' perceptions of culturally competent practice during the first 9 months post qualification.

Methods: A qualitative longitudinal study was conducted with a volunteer sample of 14 NQNs recruited from 3 Higher Education Institutions in the north of England. Data was collected using directed reflections (at 2-3 and 5-6 months) and semi-structured interviews (at 8-9 months) and analysed using a phenomenological approach informed by symbolic interactionism.

Results: Perceptions of culturally competent nursing practice were associated with core concepts such as individualised patient care, compassionate and respectful care, respecting individual differences,

professionalism and patient trust. Specific behaviours were associated with verbal and non-verbal communication, care planning and diversity-specific adjustments.

Discussion: Self-perceived competence and confidence in caring for, and interacting with, patients from diverse backgrounds developed and changed throughout the transition period with experience and interaction opportunities. An ability to reflect upon and learn from novel experiences, plus an enabling ward culture and environment which responded positively to nurses seeking advice and support was important.

Conclusion: Educational preparation may have enabled NQNs' opportunities to develop some but not necessarily all of the skills and behaviours required to demonstrate culturally competent practice. During transition, supported development and professional socialisation can assist in enhancing competence and confidence.

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Chapter 1: Introduction to the study

1.1 Introduction

Ensuring that the nursing workforce is adequately prepared to deliver care to an increasingly diverse and ever changing patient population continues to dominate debate within healthcare both in the UK and internationally. This study represents a timely inquiry into the skills and behaviours that underpin cultural competence in the UK as the competence of NQNs continues to be scrutinised prior to the implementation of the revised Standards for Pre-Registration Nurse Education (Nursing and Midwifery Council (NMC) 2010) and in the post-Francis era of healthcare delivery (Francis 2013, National Health Service (NHS) England, 2016).

The creation of a culturally competent workforce is seen as an appropriate way to facilitate the creation of compassionate, dignified and respectful health services (Papadopoulos et al. 2016). As the largest group in the healthcare workforce (Buchan et al. 2016), nurses are in a prime position to meet the needs of patients from diverse backgrounds and deliver culturally competent nursing practice (McClimens et al. 2014). In this study, perceptions are explored throughout the first nine months of professional practice. This represents a unique period of time for NQNs and is characterised by accelerated learning, professional and organisational socialisation, transition and development (Adams and Gillman 2017). NQNs perceptions and experiences of nursing care and practice during this period are shaped by the contemporary healthcare settings in which they work, and

the patients, families, carers and colleagues they interact with. Competence and confidence are enhanced during this period as the NQN assumes the role of fully autonomous practitioner.

1.2 Study aim and objectives

A study aim, purpose or research goal is important to provide an overall focus for a study with the objectives and, or research questions narrowing that focus to provide specificity which then subsequently informs the design and methods (Lewis and Nicholls 2014).

This study aimed to explore perceptions of culturally competent practice behaviour (CCPB) by NQNs.

In order to meet this aim, the study had the following key objectives;

1. To explore with NQNs their experiences and perceptions of caring for patients from diverse backgrounds
2. To explore with NQNs their perception of the skills, competencies and behaviours that constituted CCPB

This study was therefore designed to provide a contemporary perspective on this important area of professional practice grounded in the real world experiences and understanding of NQNs. This study thus augments and

extends the current evidence base and provides insight into today's nursing and healthcare practice, contributing to a more informed understanding of CCPB.

1.3 Personal statement – Why cultural competence?

This topic area has emerged from my personal and professional interest in issues related to diversity and inclusion within nursing practice and education. My own experience of understanding difference emerged as a consequence of two key influencing factors. First my own background, upbringing and childhood experiences is relevant to my interest in this area. Secondly, I have worked with people with learning disabilities, learning difference and, or mental health difficulties and their families and carers in my professional capacity as a nurse, nurse educator and researcher. Understanding the challenge of inclusion and of equitable access to health and social care, education and community provision has shaped much of my career and my personal perspectives on inclusion.

I grew up and was educated in Hull and was lucky to be surrounded by a supportive family and community who helped shape my identity. During this time, my own personal experience and that of family and friends provided me with insight into and experiences of the lives of people from diverse backgrounds. My own community was not especially ethnically diverse (reflecting the general population of the area), however it was diverse socio-

economically and inclusive of people particularly from the LGBT (Lesbian, Gay, Bisexual and Transgender) and disability communities. From an early age I was part of this diverse community and although at the time I did not consider this as diverse, different or unusual in any respect, it influenced my upbringing and my understanding of community and inclusion. By the age of 14 I was already volunteering with a youth community project supporting older people, people with mental health issues and learning disabled people. I also set up and ran a talking magazine for blind people with fellow students whilst still at school and was a volunteer in a care home for older people. These experiences influenced my understanding of what inequality meant for certain groups in society and also inspired me to pursue a career in nursing.

I trained as an adult (general) registered nurse (RN) but my first research post was in the field of learning disability, working with children with challenging behaviour, their families and carers. I became increasingly aware that people who were perceived as different as a consequence of their learning disability shared common experiences of isolation, alienation, discrimination and injustice with other marginalised groups within society. Cultural competence seemed to offer a potential model for inclusion for all that looked beyond individual difference, diversity or a single protected characteristic. The model suggested an integrated, holistic understanding of difference or otherness that linked the patient, client or service users' experience of healthcare with those responsible for its delivery.

I was able to further explore this by undertaking an MSc in Diversity Management (2011) and examined “Cultural Competency and Communication in Pre-Registration Nursing Students” for the dissertation. This initial exploratory study, like much of the other work in this field in the UK and internationally, was focused on understanding cultural competence of pre-qualifying nurses in educational settings. This provided me with insight into the educational preparation of pre-qualifying nurses and CCPB and highlighted some of the potential challenges and benefits for nurses and patients. Consequently, this PhD represented an opportunity to extend this understanding to those practising in the post-qualifying period and clarify the skills, competencies and behaviours that underpinned CCPB. This was an area that warranted further investigation and the study was motivated by a desire to enrich the current, prescriptive evidence base and to inform nursing practice and theory.

1.4 Thesis structure

The thesis has been organised into eight chapters and structured in the following way;

Chapter 1 establishes the initial reasons for undertaking a PhD in the field of cultural competence, the study aim and objectives.

Chapter 2 is divided into two main sections that contextualise the study. The first discusses legislative frameworks, health inequalities and the

organisational context of healthcare. The second section is focused on an explanation of the core concepts of cultural competence and the application of this to the experiences of NQNs during the transition from student to autonomous practitioner.

Chapter 3 comprises the literature review which sought to specifically examine the available evidence on NQNs and CCPB to inform the study development and focus.

Chapter 4 describes the philosophical paradigm and resultant methodology within which the study was positioned and the implications of this for the study design and research methods chosen. The relationship between the methodological framework and theoretical underpinning are also explored.

Chapter 5 details the study procedures including access, recruitment, ethical issues, data collection and analysis. This chapter concludes with a reflection on how the study was conducted and some of the challenges experienced.

Chapter 6 presents the main findings from the study and is structured into four key sections. The first three describe the findings in relation to each of the NQNs transition points (Transition Points (TP) 1, 2 and 3). The final section is concerned with data integration and the persisting themes, connections and interrelationships.

Chapter 7 discusses the relevance of the study findings with reference to the legislative, policy and practice context highlighted in Chapter two and the literature documented in Chapter three. The limitations of the study are provided and the chapter concludes with a reflection on the key findings with

reference to the methodological and theoretical frameworks highlighted in Chapter four.

Chapter 8 concludes the thesis by documenting the key strengths of the study and its contribution to the body of knowledge in this field of nursing practice. Recommendations are then provided for education, practice and further research.

Throughout the thesis appendices, tables and figures are provided to further explain key features of the study and emphasise salient points. Reflexivity is an essential part of engaging in a study using a particular philosophical and methodological approach situated within the phenomenological paradigm. These reflections are integrated throughout the thesis and in these sections the pronoun 'I' is used.

1.5 Conclusion

This introductory chapter provided a personal rationale as to the choice of topic and field of study as part of a PhD. This study has an overarching aim which is to explore perceptions of culturally competent practice behaviour by NQNs. The objectives for the study are stated and the subsequent development of these into specific research questions are discussed later in the thesis (in Section 4.2). An overview is also given of the thesis structure.

Chapter 2: Study context

2.1 Introduction

This chapter is divided into two main sections and contextualises the experiences of the NQNs interacting with patients from diverse backgrounds and undertaking CCPB in healthcare settings. The first section details the patient experience of health inequalities, the legislative and policy context relevant to understanding CCPB and the response from healthcare services to meet this agenda. The second section is focuses on the NQN and CCPB and addresses professional standards, skills and behaviours and provides an explanation of transition within the nursing workforce.

2.2 Health inequalities and the organisational context of care

As population diversity has increased, significant disparities in health and health care experienced by some groups in society have preoccupied healthcare providers, policy makers, governments and communities in the UK and internationally (International Council of Nurses (ICN) 2012; Bainbridge et al. 2015; American Nurses Association (ANA) 2015; Department of Health (DH) 2015; NHS England 2016a).

In the UK, public confidence in the NHS has been undermined by high profile reports of care failure (Patients Association 2012; National Voices 2012; Francis 2013; Bubb 2014) that have been derisory of the UK NHS culture which has failed to live up to the values enshrined in the NHS Constitution

(DH 2015). The NHS Constitution for England (DH 2015) documents the principles and values that underpin the NHS; articulating the rights of patients, the public and staff as well as the responsibilities that the NHS will uphold. The rights safeguarded within the constitution were manifestly clear "*You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status*." (DH 2015: 6). Central to the NHS Constitution was the importance of an organisational culture grounded in compassion, dignity and respect for both patients and staff (Kaufman and McCaughan 2013; NHS England 2016b).

However, inequalities in health outcomes and service experience for some groups have persisted despite significant investment in services. Health inequalities have remained "*persistent, stubborn and difficult to change*" (Department of Health 2009: 12) and evidence has continued to amass documenting the lack of dignity, respect and compassion experienced by some groups within UK society (EHRC 2010; Francis 2013; NHS England 2016b). In a recent international review of patient complaints (Reader et al. 2017), 13.9% of complaints related to respect, dignity and caring and a further 13.5% to the attitudes of staff. In the UK, Black and Minority Ethic (BAME) groups had less overall satisfaction with inpatient healthcare and less trust in their GPs (Chinese (42%), Bangladeshi (52%)) than their British (67%) counterparts (EHRC 2010). Older people commonly cited experiences of negative staff attitudes and behaviours and a lack of dignified care

(Cornwall 2012). Similarly, people with learning disabilities have also reported poor access to services, unmet health needs and experiences of undignified care delivery (Bubb 2014). In addition, groups with protected characteristics who experienced hostility and misunderstanding were more likely to experience poor mental health and this was a particular concern for the lesbian, gay, bi-sexual and transgendered population (EHRC 2010). Lack of compassion and poor staff attitudes has also characterised the experience of healthcare users' in the European Union (EU) (European Union Agency for Fundamental Rights (FRA) 2013).

However, it is recognised that merely improving access will not entirely eliminate systematic disadvantage (Douglas et al. 2014). Strategic approaches to reducing health inequalities have tended to be primarily concerned with socio-economic disadvantage (Marmot 2010), and the poorer health outcomes experienced by some equality groups cannot always be fully explained by deprivation or socio-economic circumstances although the two are inextricably linked (ERHC 2010). Some healthcare users may be more vulnerable because of a combination of characteristics (intersectional discrimination) placing them in a position of multiple disadvantage (FRA 2013). Discrimination experienced as a consequence of a single characteristic (e.g. gender, race, age, disability, sexuality, socio-economic status) cannot be considered in isolation as identity is multi-dimensional (Smith 2016). The legislation and subsequent enactment in law of equalities legislation (see Section 1.2) has primarily focused on individual grounds or protected characteristics, however individuals can experience systemic and

multiple forms of oppression because these personal characteristics are often inter-related (McGee and Johnson 2014).

With mounting evidence of deficits in care, poor patient experiences and systematic disadvantage, the organisational context of health service delivery in the UK continues to draw attention (EHRC 2015). In particular, the relationship between the poor experiences of patients and the treatment of staff has come under scrutiny (Klein 2017; West et al. 2017). NHS staff have reported experiences of discrimination on the basis of their ethnic background, gender, age, religion, disability or sexual orientation from managers, colleagues and patients and experiences appear to be pervasive both in the UK and internationally (Wheeler et al. 2014; Tuttas 2015). Organisational culture characterised by workplace bullying, inadequate leadership and a fear of reporting problems continues to be implicated in poor healthcare practice (Carter et al. 2013), with BAME staff groups in particular experiencing inequitable treatment (Archibong and Darr 2010; Likupe and Archibong 2013; Kline 2014).

In the NHS, disabled staff (33%) and BAME staff (31%) experienced more harassment, bullying or abuse from colleagues than their non-disabled peers (21%) and white British staff (22%) (NHS England 2016a) and were more likely to be at risk of referral to the NMC on fitness to practice issues (West et al. 2017). In addition, up to 43% of staff have reported having witnessed bullying in the workplace in the last 6 months with subsequent impacts on psychological health and well-being (Carter et al. 2013).

West et al. (2017) concluded that "*issues of racism and discrimination are prevalent throughout the NHS. Addressing discrimination requires a change in workplace culture*" (2017: 31). Within the context of significant organisational change in the UK health service, demands for efficiency savings and continuous restructuring, experiences of discrimination within healthcare organisations for both staff and patients are unlikely to improve immediately (Carter et al. 2013). The NHS Constitution (2015) has reaffirmed its commitment to core values such as dignity, respect and compassion for both staff and patients and has located these concepts firmly with a legislative framework of rights, equality of opportunity and anti-discriminatory practice (NHS England 2016a). A distinctive legislative framework in the UK has had a significant impact on how subsequent policy and procedure has been developed and enacted within healthcare settings.

2.3 Anti-discrimination legislation and healthcare services

The EU has been a key driving force in the development of anti-discriminatory legislation both across the EU and within the UK. Key to the UK legislative context was Directive 2002/73/EC (Article 1(7)) which made it mandatory for Member States to establish 'equality bodies' to monitor compliance with equalities legislation and provide support and redress for victims. With the establishment of the Equality and Human Rights Commission (EHRC) in the UK in 2006, the work of the three previously existing Commissions (the Commission for Racial Equality (CRE), Disability Rights Commission (DRC) and Equal Opportunities Commission (EOC))

were brought together with a shared focus on reducing health inequality, eliminating discrimination, strengthening good relations between groups and protecting human rights. Although equalities legislation had existed in the UK for some time, the EHRC drove the agenda for the development and enactment of the Equalities Act (2010) which replaced all previous duties with a single act.

The Equalities Act (2010) placed an obligation on 'public bodies' such as the NHS to positively promote equality for people with 'protected characteristics' in the provision of services as opposed to merely avoiding discrimination. 'Protected characteristics' referred to; age, disability, sex, gender reassignment, pregnancy and maternity, race, religion or belief and sexual orientation. A fundamental difference between the Equalities Act (2010) and the legislation it replaced was that new groups were now provided with the same levels of protection and a positive duty (Public Sector Equality Duty (PSED)) was introduced requiring public bodies to take steps to remove or minimise disadvantage and meet the needs of people with protected characteristics.

The introduction of the Equalities Act (2010) embodied the 'generalizing momentum' seen across EU anti-discrimination legislation (Somek 2011). In the previous decade in the EU, a raft of EU Directives (Equal Treatment Directive, Council Directive 2000/78/EC, Council Directive 2000/43/EC) established a general framework for equal treatment in employment and occupation and marked a major turning point in anti-discrimination legislation

by extending protection beyond gender and ethnicity to include religion or belief, disability, age and sexual orientation (Article 1). The principle of equal treatment between persons irrespective of racial or ethnic origin, also called the 'Race Directive' (Directive 2000/43/EC on Anti-discrimination) was quickly followed with directives aimed at gender parity (Directive 2002/73/EC, Gender Directive 2004/113/EC, Directive 2006/54/EC) and the establishment by regulation of the European Institute for Gender Equality (2006). The 'fixed list' approach to prohibited grounds in EU legislation was mirrored in the UK legislation by 'protected characteristics'. However, this was limited in comparison to the range and extent of included people in other countries (e.g. South Africa and Canada) and did not address intersectionality (FRA 2013; Smith 2016).

The Equalities Act (2010) did however harmonise existing UK legislation and built upon the Human Rights Act (HRA) (1998) which incorporated and made directly enforceable the rights set out in the European Convention on Human Rights (ECHR) (1950) into domestic British law. The HRA also placed an obligation on public bodies such as the NHS to respect and protect human rights and has been successfully used to challenge health inequalities and poor experiences of care (House of Lords and House of Commons Joint Committee on Human Rights 2008; Bubb 2014). However, in their review of human rights, the EHRC concluded that "*Health and social care commissioners and service providers do not always understand their human rights obligations*" (EHRC 2012: 9).

In order to address this, the EHRC have established a 'Human Rights in Health and Social Care' programme (2014-6) to raise awareness of the implications of the HRA for care commissioning and delivery and monitor compliance. The right to life, right not to be subjected to inhumane and degrading treatment and the right to family life remain particularly relevant to patients' experiences of dignity within health and social care. However, the Commission on a Bill of Rights (established in 2011) failed to reach an agreement as to the place of the HRA within the wider equalities framework of UK law. At this point it is unclear what impact the UK notification to the EU to exit Europe (Brexit) will have on the equalities landscape and health and social care provision. Although leaving the EU does not necessarily affect rights protected under the ECHR (as this is controlled by the Council of Europe not the EU), it is within the control of future UK governments to determine whether to pass legislation that may or may not be consistent with existing protections.

Following the establishment of the Equalities Act (2010) the EHRC published guidance to assist public bodies such as the NHS to comply with the general and specific equality duties detailed in the legislation. This included the requirement to publish equality objectives and progress made towards achieving them (EHRC 2010; 2014). The translation of this guidance into policy and implementation plans was however influenced by the wide ranging reform agenda within health services outlined in the then government's White Paper 'Equity and Excellence: Liberating the NHS' (DH 2010a). These proposals had "*the grand ambition of liberating the NHS*" (Hunter 2011:162),

reducing bureaucracy, increasing efficiency and delivering health service reform and cultural change focused on equity and excellence (DH 2010a). Implementing a significant level of change at a time of increased financial pressure was considered potentially risky for the NHS (Ham et al. 2015) as financial constraints had placed future public sector jobs at risk (Buchan et al. 2016). Subsequently, this resulted in a 'pause' in the proposed reform agenda within UK healthcare so that the then coalition government in the UK could conduct a listening exercise to address concerns from professional bodies, provider organisations and patients.

The White Paper 'Equity and Excellence: Liberating the NHS' (DH 2010a) was finally passed through parliament in 2012 (as The Health and Social Care Act) and established NHS England as a key organisation with responsibility for advancing equality and reducing health inequalities and ensuring that the NHS actively promoted the values in the NHS Constitution (2015). NHS England has set out how these principles and values would actually work in practice to improve the lives of all patients in 'NHS Five Year Forward View' (NHS England 2014) and has taken an active role in the Equality and Diversity Council (EDC) and the development of the Equality Delivery System (EDS) (see Section 2.3.1). The commitment of NHS England to tackling health inequality and ensuring the implementation of this agenda has yet to be realised, it may however be undermined by 'reform weary' staff (Hunter 2011).

Similarly in the EU, legislation was complimented by policy and guidance that recognised the importance of having a strategic policy approach to health across the member states as there "*exist large and perhaps increasing inequalities in health both between and within EU member states*" (European Commission 2010: 7). Health 2020: A strategy for smart sustainable and inclusive growth (World Health Organisation (WHO) Regional Office for Europe 2013) expressed the EU's commitment to speeding up progress on tackling health inequality, integrating health-related policy and driving change informed by research and evidence on social determinants (WHO Regional Office for Europe 2014). The strategy was concerned with economic, social and environmental growth and although it did not directly or explicitly address the issue of health inequalities, it was made clear that tackling health inequality was essential for this growth and development to occur. Whole government approaches were seen as crucial to the implementation of Health 2020 objectives (WHO 2015) and specifically action to address issues of poor health amongst vulnerable, marginalised and excluded groups including migrants and ethnic minorities (EU 2016).

Currently, the human rights and equalities framework of the UK, is reflected in the key NHS policy document The NHS Constitution (2015) which commits the NHS to ensuring that "*nobody is excluded, discriminated against or left behind*" (DH 2015: 5) in the provision of services. Significant investment in policy development and organisational initiatives have been put in place within the NHS, however the presence of policy has not in itself been sufficient to result in change (Government Equalities Office 2012). A review

of health sector compliance with the previous race, disability and gender duties found that compliance within healthcare was inadequate and Widger et al. (2011) concluded that **"***no authority or trust included in the sample was likely to be fully performing on all the three duties, and most were likely to have significant failings in performance*" (2011: 7).

Evaluation of the implementation of the Equality Act (2010) also indicated that there was limited awareness of the legislative changes and newly protected groups have not been fully integrated by public bodies (Government Equalities Office 2012). Allied to this was a relatively low level of engagement overall with the Equality Act and the practices that it aimed to promote (Government Equalities Office 2012). However, despite the challenge of compliance the needs of diverse client groups remained high on the NHS agenda (Patients Association 2012; Francis 2013; DH 2015) but it was clear that substantive and systemic change was needed in order to drive this agenda forward.

2.3.1 Healthcare organisations and their response to anti-discrimination legislation

The Equality and Diversity Council (EDC) was originally established in 2009 as a sub-committee of the NHS Management board with a strategic role to inform the future delivery of the health and social landscape from an equality, health inequalities and human rights perspective. Briefly renamed the

Personal, Fair and Diverse Council in 2012, it then reverted back to the EDC and was tasked with 'bringing to life' the values of the NHS Constitution (DH 2015). NHS organisations as public bodies were required to conduct equality impact assessments (EqIA) to examine organisational functions and policies and identify and address existing or potential inequalities. Many NHS Trusts and healthcare organisations established EqIA's as part of their equality analysis approach and as a credible tool for demonstrating PSED requirements. However, under the then government' 'Red Tape Challenge' there were a succession of proposals undermining EqIA (Gentleman, 2010) diluting the potential of both the Equalities Act (2010) and EqIA to systemically address health inequalities in the NHS.

In 2010, The Equality Delivery System (EDS) was commissioned by the EDC and launched in July 2011 to help NHS organisations improve services provided for local communities and develop more inclusive working environments for staff. A review of the EDS in 2012 (Shared Intelligence, 2012) concluded that although the EDS had led to increased awareness and commitment to equality across organisations, process rather than outcome continued to be the organisational focus. A preoccupation with process issues to meet legislative demands had similarly plagued EqIA, and equality continued to be perceived as separate to core business in the NHS, an 'add on' activity, a problem to be fixed that served to reinforce minimum compliance with the legislation rather than the practices it aimed to promote (Myers and Wooten 2009). The EDS also appeared to provide limited

evidence of improved outcomes for patients, other than a 'perceived' improvement in engagement (Shared Futures 2012).

The EDS toolkit was complimented by additional initiatives from the EDC such as the Personal, Fair and Diverse Champions campaign (led by NHS Employers) and more recently, the Workforce Race Equality Standard (WRES). The latter specifically introduced in response to highlighted disparities in the number of BAME people in senior leadership positions across the NHS, as well as the less favourable treatment of BAME staff (Archibong et al. 2013; Klein, 2014). In response to earlier criticisms of the EDS (Shared Futures 2012), a revised EDS2 was developed and importantly mandatory requirements for both EDS2 and WRES were introduced in 2015 emphasising the commitment of both EDC and the NHS to the delivery of equitable and inclusive healthcare. The impact of these initiatives on organisational culture within the NHS has yet to be determined, however a recent review into the EDC terms of reference concluded that "*There are concerns that the EDC looks towards processes, such as EDS2 to resolve problems and fails to have a reality check as to if these processes are actually having an impact*" (NHS England 2015: 6).

Given the variable levels of engagement with previous legislative requirements, future compliance remains doubtful without a substantive refocusing of both the EDS2 and WRES on outcomes rather than process. In addition, engagement with EDS had previously tended to involved mainly race and disability interests (Shared Futures 2012) and other (protected)

groups have been less well represented. Consequently, the organisational systems may well be in place in the NHS to address equality (and inequality) but this will not necessarily ensure they are enacted in practice without further investment or commitment across the NHS. However, the most recent report reviewing WRES (Kline et al. 2017) has indicated a positive change with increased number of nurses and midwives progressing from lower grades into more senior positions, including senior management and a slight reduction in the reported experience of discrimination of BAME staff from colleagues and managers. This is commendable progress however, as West at al. 2017 have indicated "*It is hoped that a focus on race equality will lead to more robust efforts on all equality strands (though previous research suggests this is unlikely to be the case)*" (2017:10).

Whilst there are evident difficulties within healthcare organisations in addressing health inequalities and delivering on the EDS2 and WRES, these challenges must be considered within the context of an unprecedented level of change in health services across the UK. In 2015, 93% of NHS trusts in England reported registered nurse shortages (Buchan et al. 2016) and on-going austerity measures, limited resources and competing priorities (Butterworth 2014) may well have compounded the challenge faced by frontline staff to deliver the changes needed to implement the equalities agenda. Thus despite an expressed commitment to putting patients first, implementing the necessary changes has remained problematic (Ali et al. 2012).

2.3.2 Organisational equalities and cultural competence

Despite concerns with the delivery of WRES and EDS2, these systems have provided an organisation-specific equality focus for the UK health sector, designed to embed equality and diversity into all levels of the organisation in order to change its culture (Bhui et al. 2007). WRES and EDS2 thus can be seen to represent a longer-term, strategic approach aimed at mainstreaming equality into wider organisational systems and infrastructure (leadership and accountability, benchmarks, standards, policy and data monitoring, staff and patients/clients engagement) (O'Mara and Richter 2006; DH 2011). EDS2 and WRES, thus provide a mechanism by which the NHS and other health providers might create a culturally competent healthcare organisation (Douglas et al. 2014).

Although significant investment has been made to promote diversity in leadership positions with the NHS, this does not appear to be have been universally successful (Archibong and Darr 2010; Kline 2014; West et al. 2017). BAME representation at senior levels is poor both within the NHS and other national health authorities (e.g. Monitor, the CQC) and this appears to have worsened over time (Klein 2014) although WRES has made some recent impact (Kline et al. 2017). Organisational commitment in the form of Diversity Champions and Equality and Diversity specialists have significantly raised awareness and influenced organisational culture, but the presence of a clearly defined role in equality and diversity has not resulted in change (Government Equalities Office 2012).

The most robust elements of the EDS2 and WRES systems to date have been at data gathering, monitoring and reporting levels and these will not of themselves ensure progression on health inequalities or staff discrimination. Both the Francis Inquiry (Francis 2013) and Winterbourne View Scandal (Bubb 2014) recommended that an organisational culture of defensiveness and scapegoating should be replaced by one of openness in which concerns can be raised and inclusive, respectful care is delivered (Kaufman and McCaughan 2013). One mechanism by which health services in the UK and internationally have sought to respond to diverse patient needs and health inequalities is through the development of an appropriately skilled workforce (Henderson et al. 2011; Lie et al. 2013; Loftin et al. 2013; Horvat et al. 2014).

The largest group of employees within the NHS is nurses, midwives and health visitors with a ratio reported in 2013 to be 8.3 per 1,000 population, although this is lower than other countries such as the US, Scandinavia, Canada, Australia and New Zealand (Buchan et al. 2016). The nursing workforce has "*a crucial role to play in enhancing the patient experience*" (NHS Employers, 2009b: 8) and to deliver patient centred, safe and effective care, prevent patient dissatisfaction, cultural misunderstanding and subsequent poorer health outcomes (Teal and Street 2009; Allen 2010; Loftin et al. 2013; Papadopoulos et al. 2016).

Although staff training in cultural competence within healthcare has been promoted as a way to influence patient outcomes and health inequalities, evidence remains limited (Loftin et al. 2013; Gallager and Polanin 2014). In

addition, underlying this is an assumption that staff training and development will have a positive impact on health inequalities. However, Lie et al.'s (2013) systematic review found limited evidence of a positive relationship between training staff in cultural competency and improved patient outcomes. However, they acknowledged that overall the quality of studies included in the review were low and there was a paucity of evidence to ascertain effectiveness. Similarly in Henderson et al.'s (2011) systematic review of cultural competency training and culturally appropriate interventions to manage chronic disease in diverse communities, they reported support for the use of bi-lingual health workers and not staff training in cultural competency. Both, Horvat et al. (2014) and Gallager and Polanin (2014) appeared to be in agreement, that there was 'some' support for investment in cultural competence training or education but that further research was needed. Despite inconclusive and sometimes contradictory evidence, enhancing workforce competency via education and training of front line staff such as nurses has continued to be a key strategy within health services to address health inequalities and to address structural and systemic disadvantage (Williams et al. 2014).

Having explored the patient experience of health inequalities, the legislative framework and organisational context of healthcare, the second part of this chapter is focused on the NQN and CCPB. This includes the regulatory framework, an exploration of the core concepts of cultural competence and the application of these within the context of the NQNs transition from student to autonomous practitioner.

2.4 NQNs and professional standards

The expectation is that those who enter the profession of nursing will be sufficiently skilled to deliver efficient, safe, effective, evidence-based quality care to all patients in accordance with the values, ethics and standards regulated by the profession (NMC 2014; 2015). Within the UK, the NMC has set the standards for nurses and midwives in relation to education, training, conduct and performance. Achievement of competence articulated in the *Standards for Pre-registration Nursing Education* (NMC 2010) is a requirement for entry to the NMC register and is defined as "*the combination of skills, knowledge and attitudes, values and technical abilities that underpin safe and effective nursing practice and interventions*" (NMC 2010: 11). In addition, NQNs must uphold and comply with all the standards of professional practice and behaviour detailed in the Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (NMC 2015) (hereafter referred to as 'The Code'). The Code sets the standards expected of nurses and midwives throughout their careers, reinforcing professionalism and is central to post-qualifying revalidation with the NMC in order to remain registered to practice.

The Code's has four key areas; prioritise people, practise effectively, preserve safety and promote professionalism and trust. The first standard in particular is relevant to understanding CCPB (prioritising people) and states that all nurses are expected to "*make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory*

attitudes and behaviours towards those receiving care are challenged" (NMC 2015: 4). In order to meet this standard, all nurses must "*Treat people as individuals and uphold their dignity*" (NMC 2015: 4) and what this means in practice for nurses is specifically (my italics below);

"1.1 treat people with *kindness*, *respect* and *compassion*

1.2 make sure you deliver the fundamentals of care effectively

1.3 *avoid making assumptions and recognise diversity and individual choice*

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay, and

1.5 *respect and uphold people's human rights*." (NMC 2015: 4)

Consequently the Code (NMC 2015) also reflects the human rights and equalities framework of the UK and the NHS Constitution (DH 2015). Terms such as practising with compassion, respecting individual differences, individualised patient care i.e. 'the language of care and nursing' (Allan et al. 2007) are found in abundance throughout UK healthcare policy and practice (DH 2015; NHS England 2016b) and professional guidance such as the RCN's Principles of Nursing Practice (Principle A) (RCN 2010) and The Chief Nursing Officer's '6 Cs'; Care, Compassion, Competence, Communication, Courage and Commitment (DH 2012). Although differences in terminology exist between countries, the values of nurses and nursing, the expected behaviours and standards are shared internationally. These include for example; International Council of Nurses (ICN) (2012), Code of Ethics for

Nurses; The Nursing and Midwifery Board of Australia (2013) Code of Ethics for Nurses and Code of Professional Conduct; the ANA (2015), Code of Ethics for Nurses with Interpretative Statements and the National CLAS Standards (Culturally and Linguistic Appropriate Service in Health and Health Care) (Office for Minority Health (OMH) 2013).

2.4.1 Professional standards and cultural competence

These standards underpin nursing practice, professionalism and accountability and substantially impact upon the working lives and experiences of the NQNs in this study. The term cultural competence has not been explicitly used in the aforementioned UK regulatory and policy documents unlike comparable nursing guidance available in the US (ANA 2015) and within Social Work (Abrams and Moio 2009). They do however have sufficient commonalities or meaning and the core attributes of CCPB can be correlated with nursing proficiencies, values and the language used to describe them. In particular the focus on individualised or patient centred care (Saha and Beach 2008; Zhao et al. 2016), respecting individual differences (Gallagher and Polanin 2014; Cai 2016) and compassionate care (Bray et al. 2013; Papadopoulos et al. 2016). Attributes such as kindness, empathy, openness and respect are routinely associated with CCPB as well as nurses and nursing and the similarities in language and meaning across these two constructs have led some to question the difference between CCPB and the core competencies of nursing (Jirwe et al. 2009).

Whilst this is a legitimate concern within the field of cultural competence, it is equally evident that regardless of the preferred term used, NQNs should be able to demonstrate a sufficient level of sensitivity to, and awareness of, the culturally diversity of the patients they care for (Calvillo et al. 2009), in order to meet the standards detailed in the Code (NMC 2015). In the Standards for competence for registered nurses (NMC 2014), the NMC specifically states that NQNs should "*adapt their practice to meet the changing needs of people, groups, communities and populations*" (2014: 6). Whilst this is not explicit in terms of referring to people from diverse backgrounds, this statement infers changing diversity within the patient population and a requirement to respond to that diversity. The debate as to whether CCPB and core nursing values and competencies overlap, are similar and, or independent of each other is indicative of the on-going ambiguity within the field of cultural competence as to the latter's specificity, definitions, focus and meaning.

2.5 Understanding cultural competence

Definitions of cultural competence are abundant (The London Deanery 2009) and one of the most commonly cited is that of Cross et al. (1989) which defined cultural competence as *'A set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross cultural situations' (*Cross et al. 1989*).*

However, Betancourt (2003) provides a more comprehensive definition that is focused on the health care system;

‘*A "culturally competent" health care system has been defined as one that acknowledges and incorporates, at all levels, the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs. A culturally competent system is also built on an awareness of the integration and interaction of health beliefs and behaviours, disease prevalence and incidence, and treatment outcomes for different patient populations”.*

In the US, the National CLAS Standards recommended 14 steps for health providers and organisations to develop and implement cultural and linguistic competency (OMH 2013). Cultural competence in the CLAS standards was seen as “*effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs*” (OMH 2013: 1).

These definitions draw attention to different conceptualisations of CCPB and whether it is applicable at both individual and, or organisational level. Whereas Cross et al. (1989) reflects organisations, the systems within it and individuals. Betancourt’s definition (2003) however does not necessarily address individual responsibilities although this is implied in the phrase ‘at all

levels', it remains primarily focused on organisational cultural competence. However, the health beliefs of the patient are acknowledged and this is connected to health inequality (or inequality). Similarly, the CLAS Standards (OMH 2013) are primarily focused on organisations and in particular communication, workforce issues and quality improvement.

In addition, two core concepts are contained within cultural competence; culture and competence. Culture can be seen as "*a learned set of shared interpretations about beliefs, values, norms and social practices*" Lustig and Koester 2010: 25) which influence how particular groups think, behave, interact and make sense of the world, their communities and their place within it. In this study, both the individual culture of the NQNs as well as the organisational culture of the workforce setting is considered. Competence in nursing practice (and in this study) is linked to the NMC Standards (2010; 2014). Competence presumes capacity to undertake tasks and, or skills and can be considered as a behaviouristic notion, or in a more holistic sense to focus on general characteristics or attributes essential for effective performance (National Nursing Research Unit (NNRU) 2008).

One of the persistent themes in the literature on cultural competence is the concern regarding ambiguity of terms and lack of operational clarity (Jirwe et al. 2009; Horvat et al. 2014; Gallagher and Polanin 2015). Arguably, this is one of the few matters that academics, theorists and researchers within the field appear to agree upon. Although this study used the term cultural competence, there are a number of other terms used interchangeably within

the literature such as cross-cultural competence, culturally congruent care, transcultural nursing, intercultural competence (Horvat et al. 2014; Cai 2016).

In their review of definitions of cultural competence, the London Deanery concluded "*it becomes clear that no single definition of cultural competence is yet universally accepted, either in practice or in health professions education. Therefore considerable confusion exists about what constitutes cultural competence*" (2009: 5). Similarly, Shen (2015), identified twelve different definitions and eighteen different models of cultural competence available in the literature. Inconsistencies in terminology are also prevalent within research studies exploring cultural competence, with authors rarely providing explicit definitions (Horvat et al. 2014).

The range and extent of definitions and models in addition to variability in meaning contributes significantly to the lack of clarity in the literature, and what is meant by the term cultural competence is often country specific. For example, cultural safety emerged from a uniquely New Zealand perspective grounded in critical theory, and primarily concerned with repression, domination, class and power (Doutrich et al. 2012).

Similarly, in the US cultural humility has recently emerged as alternative and preferred term to cultural competence and has been defined as a "*process of openness, self-awareness, being egoless, and incorporating self-reflection and critique after willingly interacting with diverse individuals*" (Foronda et al. 2015: 213). The important distinction here is that the focus is on the

individual practitioner and self-humility within the context of the patient – nurse relationship rather than on a specific level or knowledge, awareness and competency that should (and, or could) be achieved.

Arguably, given these differing terms and conceptual overlap the resultant confusion in interpreting CCPB in nursing practice is not unsurprising. However, this is a likely consequence of the development of a number of different theories and concepts of cultural competence that have evolved over a period of time, reflecting different national contexts and concerns. Much of the research and theory in this area developed within the field of transcultural nursing in the US and Madeline Leininger, a nurse and anthropologist first used the term 'culturally congruent care' (Leininger 1988, 2002). CCPB emerged from, and was associated with, this historical tradition and work specifically developed to address racial and ethnic health inequalities and discrimination in the US (Campinha-Bacote 2002; Fitzgerald et al. 2009, Jirwe et al. 2009). Leininger's pioneering work provided a platform for the development of other models and frameworks that proliferated in healthcare both in the UK and internationally. A brief overview of some of the key models is provided in Appendix 1. As the focus of this study is exploring the perceptions of CCPB by NQNs, information regarding skills, behaviour and, or competencies is highlighted.

The association of 'culture' in cultural competency almost exclusively with ethnicity has persisted within the academic literature (Kim-Goodwin et al. 2001; Loftin et al. 2013) including within the UK (Shared Values 2012),

further adding to conceptual confusion. However, in order to address CCPB in this thesis, the definition proposed by Loftin et al. (2013) in their integrative review of measures of cultural competence in nursing will be used. This is based on Giger and Davidhizar's work (2004):

"*having the knowledge, understanding, and skills about a diverse patient group that allows the healthcare provider to provide acceptable cultural care. Competence is an on-going process that involves accepting and respecting individual differences*" (Loftin et al. 2013: 2).

'Healthcare provider' in this context is taken to refer to the individual (nurse) and key to this definition is the notion of 'understanding' characterised by both 'accepting and respecting individual differences' consistent with the NMC Code (NMC 2015). Although 'healthcare provider' could also be applied to an organisation, as this study is concerned with NQNs (as individuals), a definition which is primarily focused on the individual is deemed more appropriate than others. There does however appear to be potential for ambiguity within this definition, for example, what constitutes acceptable cultural care and from whose perspective is that determined? The patient? The nurse? Or the organisation? Notwithstanding this concern, for purposes of transparency and precision a definition must be chosen.

Although models of cultural competence were derived from predominantly a US perspective, they have been applied and used within nurse education, nursing practice and health care settings across the world (Loftin et al. 2013;

Douglas et al. 2014; Polanin and Gallager 2014). It cannot be assumed however, that these can be applied to the UK experience as there are differences in focus between countries. US and UK models have tended to consider CCPB as concerned with interaction between nurse and patient from different cultural backgrounds (Jirwe et al. 2009), recognising the central role of caring and care to this relationship (Leininger 2002). Whereas, New Zealand takes a broader view that all encounters between nurse and patient are in effect cross-cultural (Foronda et al. 2015).

Others provide an organisational perspective on CCPB (Bhui et al. 2007), or integrate organisational and individual cultural competence (Loftin et al. 2013). In addition, the emphasis placed on anti-discriminatory practice and the responsibility of the nurse to challenge this varies between countries and models (Jirwe et al. 2009; Foronda et al. 2015). For Papadopoulos et al. (2006), the ability to recognise and challenge discrimination and oppressive practice is fundamental to the delivery of CCPB, and explicitly linked to health inequalities and the human rights agenda. Authors do however appear in agreement that cultural competence can best be understood as a process (Campinha-Bacote 2002; Loftin et al., 2013) although it has also been associated with the notion of outcome (Bhui et al. 2007). There seems to be no compelling reason to argue that cultural competence is an outcome, however the very nature of the term ‘competence’ assumes that this is something achievable that one can become proficient in. That is, the process of acquiring cultural competence has an end result - that of being a culturally competent practitioner. The development of the skills and abilities of CCPB

are evidently incremental (Teal and Street 2009), and have synergy with the notion of graduated competency in pre-registration nurse education in the UK (NMC 2010 2014).

However, whilst some nursing (clinical) competencies can be objectively measured and achieved (e.g. the correct administration of a medication), CCPB is significantly more complex and multi-faceted and is better understood as "*an active process of learning and practising, this evolves over time and requires a constant commitment*" (Calvillo et al. 2009: 140). This focus on life-long learning and commitment underpins cultural humility, a contemporary response and challenge to the notion of CCPB as something that the individual nurse can achieve and, or be competent in (Foronda et al. 2015).

The evolution of cultural competence, changing terminology, lack of operational clarity and limited consensus as to preferred terms has negatively affected its potential for measuring impact on patient care and health inequalities (Loftin et al. 2013; Horvat et al. 2014). The lack of reliable outcome measures to evaluate and research the impact of cultural competency has been persistently reported in the literature (Krainovich-Miller et al. 2008; Olt et al. 2010; Loftin et al. 2013). Where measures have been developed they have tended to be primarily self-report instruments (for example, Campinha-Bacote's Inventory for Assessing the Process of Cultural Competence Among Health Care Professionals IAPCC-R (revised) (Kardong-Edgren and Campinha-Bacote 2008), used with mainly student

populations and relied primarily on convenience sampling (Loftin et al. 2013). In addition, the self-report measures assume that the person who is best placed to determine whether they are culturally competent or not are the individual nurse rather than the patient. Patient perspectives on CCPB is recognised as a limitation of research within the field (Jirwe et al. 2009; Chang et al. 2013; Shen 2015), and the lack of impact on health outcomes a likely consequence of this (Loftin et al. 2013).

2.5.1 Core concepts of cultural competence

Whilst there are evidently differences between models in terms of how they articulate the core domains and key skills, commonalities exist in relation to cultural awareness, cultural sensitivity, cultural knowledge, cultural skills, cultural encounters and cultural desire or motivation (Loftin et al. 2013; Horvat et al. 2014; Shen 2015). These differences and similarities are further discussed throughout the remainder of this section.

Cultural awareness requires practitioners to critically reflect upon their own conscious or unconscious beliefs and explore the impact of this on their interaction with patients (Papadopolous 2006; Cai 2016, Papadopoulos et al. 2016) a quality Teal and Street (2009) described as “mindfulness” (2009: 533). Health care professionals have been shown to have implicit race and skin tone biases and a lack of awareness has consequences for the patient – practitioner interaction (White-Means et al. 2009). Therefore, NQNs need to be aware of the impact of their own assumptions regarding particular groups

and the potential impact of this when delivering care and interacting with patients (Krauskopf 2008; Teal and Street 2009; Papadopoulos et al. 2016).

The importance of this awareness and avoiding assumptions is also specifically mentioned in 1.3 of the Code (NMC 2015) and this domain is consistent with cultural safety which requires the individual nurse to engage in reflection and 'know yourself' (Doutrich et al. 2012). Similarly, cultural humility with its focus on self-awareness, open and egoless interactions requires an intensive approach to self-reflection and critique (Foronda et al. 2015). Jirwe et al.'s (2009) Delphi study exploring the core components of cultural competence concluded that cultural sensitivity was an important precursor to the development of CCPB. Awareness, is more appropriately described as cultural self-awareness, requiring critical reflection (Douglas et al. 2014) and, or a cultural self-assessment (Horvat et al. 2014).

Whilst cultural awareness is focused on the practitioner, cultural sensitivity refers to an awareness and appreciation of the patients' or clients' cultural diversity, as opposed to self-awareness (Cai 2016). Kim-Goodwin al. (2001), saw awareness as a precursor to cultural sensitivity and recognising and respecting the cultural perspective of the patient is also central to cultural safety (Doutrich et al. 2012). However, awareness would appear to infer knowledge of, whereas appreciation would seem more suitably aligned with cultural desire (discussed below).

Knowledge of core cultural issues is generally advocated in order to understand the patients' perspective (Bhui et al. 2007; Jirwe et al. 2009; Cai 2016). However, there is debate as to what constituted a sufficient amount of cultural knowledge (Foronda et al. 2015), as knowledge in the form of cultural 'do's and 'don'ts' (Cai 2016) runs the risk of assuming a heterogeneity within specific cultures or a 'trait list' approach (Kleinman and Beson 2006). This can undermine patient choice and individual preferences (McClimens et al. 2014) and "*oversimplification of cultures*" can occur (Naravanasamy and White 2005: 107) if knowledge is focused on stereotypical assumptions regarding a particular group (Teal and Street 2009).

Some models specifically include knowledge of health inequalities, anti-racism and challenging discrimination (Papadopolous 2006), however, in others this is not always explicit (Jirwe et al. 2009). Allan (2010) argued that this should be included in models as this was an expectation of the profession as well as the general public. The NMC Code (NMC 2015) expects NQNs to "*challenge poor practice and discriminatory attitudes and behaviour relating to their care*" (NMC 2015: Section 3.4). However this presupposes that NQNs are able to recognise and understand what is meant by discriminatory attitudes and behaviour in relation to care. Experienced staff are challenged to deliver on this particular standard as evidenced by the surfeit of reports detailing poor practice (National Voices 2012; Francis 2013; EHRC 2015). Arguably, NQNs cannot challenge what they do not perceive as discriminatory and the organisational culture in which they work may well

determine what is considered acceptable norms of practice (Higgins et al. 2010; Rush et al. 2013).

For NQNs, having a substantive knowledge of all cultures is unlikely at the point of registration, however cultural knowledge should (theoretically) develop as a consequence of increased interaction with patients (Douglas et al. 2014). This increase in both knowledge and skills occurs as a consequence of the cultural encounter; a central and pivotal concept within the models shown in Appendix 1. Campinha-Bacote (2011) argued that the cultural encounter is the 'foundation stone' of cultural competence, a necessary pre-requisite to the development of CCPB. Although engaging in the cultural encounter does not necessarily ensure that cultural competence will develop, it does however provide the nurse with the opportunity to learn about different cultural groups and reframe understanding and beliefs about particular cultural groups (Cai 2016).

Whilst the importance of practice skills are commonly cited within frameworks discussed in the literature on pre-registration nursing (Krainovich-Miller et al. 2008; Jirwe et al. 2009; Allen 2010), explicit examination of CCPB in nursing practice remains limited, a deficit acknowledged by Ahmed and Bates (2012). The paucity of research into practice skills is a likely consequence of conceptual differences and ambiguity in terminology discussed previously. If there is no clear consensus as to a definition or clear operationalisation of terms, then its application to nursing practice and the patients' experience of healthcare is likely to prove challenging if not unfeasible. In addition, the

extent to which practice skills feature within models of cultural competence is often determined by whether the model is focused on culture or on competence (Shen 2015).

However, there are two key areas in relation to the skills that are recurrent themes within all models of cultural competence; cultural assessment and communication skills. Leininger (2002) encouraged healthcare professionals to conduct a holistic 'culturalological' assessment and this included biological, psycho-social, economic, educational, environmental and political and, or economic factors. These multiple level factors are applied by the nurse to maintain, accommodate or re-structure a patient's health, care and lifestyle in a way that is meaningful for them (Leininger, 2002). Similarly, both Campinha-Bacote (2002) and Papadopolous (2006) interpreted cultural skill as requiring the nurse to incorporate cultural data into the assessment of patient needs.

Whilst cultural assessment as a framework or assessment tool for determining patient needs appears to be prevalent in the US, it has not been implemented significantly in the UK (Holland and Hogg 2010). That is not to say that assessment of cultural needs does not occur, however the extent to assessment and care planning in the UK meets the criteria for a holistic 'culturalological' assessment as advocated by Leininger (2002), Campinha-Bacote (2002) and Papadopolous (2006) can be questioned. Jirwe et al. (2009) in their study of practising nurses in Sweden found that they were less likely to consider ethno-history as important when compared to academics or

researchers despite the fact that cultural assessment was considered essential to care planning (Douglas et al. 2014).

Cultural assessment then, seeks to determine the cultural practices, beliefs and preferences of the individual patient or client and then incorporate these into the plan of care. However, it is possible to argue that in order to undertake a cultural assessment, the nurse must be sufficiently culturally competent in the first place. Undertaking a formal assessment requires the nurse to have a considerable level of cultural awareness, sensitivity and knowledge and this may be outside the competency range of most NQNs upon qualification (see Section 2.5.2). According to Campinha-Bacote (2011) the cultural encounter provides the nurse with an opportunity to interact with patients from different cultural backgrounds and develop cultural desire, awareness, skill, and knowledge. However, the skill of cultural competence could also been seen as the active application of the domains of cultural desire, awareness, skill, and knowledge to the 'patient encounter' (Campinha-Bacote 2002). In addition, Bennett (2008) noted that engaging in cultural contact does not necessarily result in the development of cultural competence.

Leininger (2002), specifically considered care and caring as central to cultural competence and this was an action (the act of providing care) that took into account individual differences (the beliefs, values and modes of care). The actions that the nurse takes in response to a cultural encounter can be seen to be an application of their knowledge, awareness, skills and sensitivity to

this interaction, with this patient, and in this context. Implicit within this model was that although there were commonalities between groups, heterogeneity was not assumed. Along similar lines (and built upon the work of Leininger (2002)), Giger and Davidhizar's (2004) framework of assessment and intervention was focused on six core cultural domains which they considered relevant to all groups. Rather than focused on cultural specificity, generic phenomena assumed that each person was essentially culturally unique, an individual.

Campinha-Bacote's more recent work in the field (Campinha-Bacote 2011) has linked assessment skills with the ability to collect relevant cultural data in order to deliver patient centred care. Saha et al. (2008) argued that advocates of cultural competence see their construct as one aspect of patient centred care, whereas proponents of patient centred care assert the opposite. There is evidently overlap between these two and both are concerned with improving care quality (Zhao et al. 2016). The key difference is that cultural competence has placed a greater emphasis on addressing health inequalities and challenging discrimination, although this is not always explicit in some models or approaches.

Communication continues to be advocated as the most important skill in CCPB (Campinha-Bacote 2002; Leininger 2002; Johnson 2004; Teal and Street 2009; Kodjo 2009; Papadopolous et al. 2016). This is consistent with requirements for professional nursing practice in the UK (NMC 2014; 2015). Effective patient-clinician communication improves patient satisfaction with

healthcare (Chang et al. 2013) and enables nurses to translate their knowledge, awareness and sensitivity into CCPB's. Although all nurses are trained in communication skills, competence and confidence in communicating with people from diverse backgrounds are required to prevent cultural misunderstandings (Kai et al. 2007; Jirwe et al. 2009; Teal and Street 2009).

CCPB as communication may be as Teal and Street (2009) have suggested "*an integrated set of specific communications skills that reflect one's development along a continuum of cultural competence*" (2009: 536). In addition, rather than applied to one specific skill such as cultural assessment, communication is a developmental competency that is applied to interactions with patients as integral to on-going nursing care and delivery. This includes 'cultural brokerage' (Thom and Tirado 2006), 'cultural negotiation and compromise' (Naravanasamy 2002) or cultural care negotiation (Leininger 2002).

The interaction or encounter then can be seen to include both communication skills and behaviors (Lustig and Koester 2010; Perry and Southwell 2011) and NQNs ability to conduct a formal cultural assessment is dependent upon and inextricably linked to their cultural competence and specifically communicative competence. Effective verbal and non-verbal communication skills are required in all interactions with patients, however, Horvat et al.'s (2014) reported that studies tended to focus primarily on cultural assessment

processes and, or, communication as the primary skills and most studies were not clear as to what skills (communication or otherwise) they were referring to.

The dominant discourse in relation to communication appears to be on barriers and challenges when there is no shared language proficiency between nurse and patient (FRA 2013; Chang et al. 2013; Hart and Mareno 2014; Ali and Johnson 2016). Language difficulties are a key barrier for marginalised and, or disadvantaged groups in terms of accessing and receiving healthcare (EHRC 2010; Douglas et al. 2014; Ali and Johnson 2016). When language proficiency is not shared, translation services or an interpreter may be a more effective way of communicating (Cai 2016), or the use of bi-lingual colleagues (Ali and Johnson 2016). Although using patients' families and friends as interpreters for the patient is not advocated in practice because of potential ethical conflicts, this appears to be a common occurrence (Jirwe et al. 2009).

Communicating in a culturally competent way requires sensitivity to both verbal and non-verbal communication cues, of the patient as well as the nurses own (Krauskopf 2008). The literature has tended to focus habitually on language barriers rather than an understanding of the range of verbal, linguistic or communication skills and behaviours that comprise 'cultural fluency' in communication (Mor Barak 2005). This may serve to emphasise the point that the patient is diverse or other, locating the 'problem' of communication with them rather than the nurse (Jirwe et al. 2009). In

addition, this reinforces the message that this is an issue related specifically to ethnicity or nationality rather than reflecting the different groups accessing healthcare who may have communication needs (Abrams and Moio 2009). Allen (2010) has argued that "*transcultural nursing has been privileged in the nursing literature*" (Allen 2010: 320) and this may have created an emphasis on race, ethnicity and religion. However, there has been an increasing recognition that cultural competence needs to see beyond ethnicity, religion and race and embrace other identities (Foronda et al. 2015), and see communicative competence beyond language barriers (McGee and Johnson 2014).

Cultural desire has been described as "*the motivation of the health care provider to want to, rather than have to, engage in the process of becoming culturally aware, culturally knowledgeable, culturally skilful and familiar with cultural encounters*" (Campinha-Bacote 2002: 182). Although not initially included in Campinha-Bacote's earliest formulations of cultural competence, its importance cannot be overstated as it arguably key to driving individual willingness to engage with the other domains. This motivation, has remarkably similar undertones to the more contemporary concept of cultural humility which requires an openness and willingness to engage in interactions with people from diverse backgrounds (Foronda et al. 2015). This requires conscious effort and commitment and must be authentic (Calvillo et al. 2009).

Cultural desire arguably plays a key part in driving the development of CCPB and has been seen as a precursor (Issacs et al. 2016) or antecedent (Cai 2016). Without cultural motivation or desire, then cultural awareness, sensitivity and knowledge may not develop. However, cultural desire or motivation appears to be the least developed of the constructs probably reflecting its delayed prominence within models. Issacs et al. (2016) found that although student understanding of Aboriginal health increased after completing a specific module, their overall cultural desire did not. They concluded that this was because cultural desire might take time to develop. However, if this takes time to develop it questions the validity of arguments positioning cultural desire as a precursor or antecedent to awareness and knowledge.

One of the significant developments in understanding CCPB has been a reframing of models to take into account antecedents as well as consequences and attempting to link these via cultural competence. Cai's (2016) proposed concept analysis understood cultural competence in terms of antecedents (cultural diversity, cultural encounters, cultural desire) as well as consequences (patients/clients, nurses and organisations) and these included outcomes on health inequalities and satisfaction with services and increased adherence to treatment regimens (Ingram 2012; Cai 2016).

Similarly cultural humility (Foronda et al. 2015) and cultural safety (Doutrich et al. 2012) represent an explicit and direct challenge to cultural competence as the dominant paradigm in this field. Representing a movement away from

a focus on domains related to demonstrating skills, competencies and behaviour, these frameworks start with the individual practitioners' values, beliefs, and assumptions. These are challenged, developed and enhanced through a process of self-critique and examination and a commitment to reflection and life-long learning. In effect, both cultural humility and cultural safety are consistent with core attributes in traditional models of cultural competence such as sensitivity, humility, awareness and desire.

With a limited and inconclusive evidence base to link cultural competence training or education with better patient outcomes (Henderson et al. 2011; Lie et al. 2013; Horvat et al. 2014), discussions of cultural competence appear to be moving away from a focus on competence and proficiency. Competence assumes an end outcome that is achievable whereas cultural humility encourages a process of on-going learning, reflection and personal growth and development (Foronda et al. 2015). This is not incompatible with the NMC Code (2015).

2.5.2 CCPB and educational preparation

Studies examining cultural competence within pre-registration education appear to agree that irrespective of model or teaching approach used cultural awareness and knowledge is enhanced but cultural competence is rarely achieved (Krainovich-Miller et al. 2008; Jirwe et al. 2009; Waite and Calamaro 2009; Allen 2010). However, given that there is a lack of consensus as to how cultural competence should be taught (Allen 2010), or

which model or framework is the most suitable (Foronda et al. 2015), it is unsurprising that "*educators are challenged*" to create a suitable curriculum (Calvillo et al. 2009: 138). It may well be that educational preparation primarily addresses the 'knowing that and why' of cultural competence (conceptual and cognitive) rather than the 'knowing how' (functional competence) in relation to this area of practice (Wilson and Myers 2000). Situated learning which embeds the 'knowing how' may not have taken place during pre-qualifying education and nurses may complete the programme without sufficient experience interacting with patients from diverse backgrounds.

Lie et al.'s (2013) systematic review of cultural competency training of health professionals updated the work of Beach et al. (2005), adding four new studies to the review. Both reviews reported that there was insufficient information on the curricula, intervention or other potential variables within studies included to ascertain any impact. Similarly, Gallagher and Polanin's (2015) meta-analysis of educational interventions to enhance cultural competence in professional nurses and nursing students suggested the need for greater transparency on curriculum interventions. They did however, report that despite these challenges there was some indication that qualified nurses benefitted from cultural competency training more so than students. Likewise, in a systematic review (of reviews) of interventions to improve cultural competency in healthcare, Truong et al. (2014) concluded that evidence of impact in terms of patient outcomes was weaker than that of provider outcomes or access.

Consistent across all these reviews (Beach et al. 2005; Lie et al. 2013; Truong et al. 2014; Gallagher and Polanin 2015) are concerns regarding ambiguity in definition, language and terminology and a lack of methodological rigour. The persistent confusion surrounding definition and understanding of key concepts have undermined clarity during educational preparation compromising the ability of educators to successfully connect the core constructs of cultural competence with day to day nursing practice. Whilst there is some limited evidence of effect of educational interventions, NQNs report not feeling confident or adequately prepared to deliver CCPB despite their formal training (Waite and Calamaro 2009). However, opportunities for competence enhancement are amplified during the first few months during transition into professional practice (Lima et al. 2016). Therefore, it is hypothesised as theoretically and conceptually possible that the skills of CCPB would develop during the transition period.

2.6 Understanding the transition period

Whilst a number of studies bemoan the skill deficit of NQNs upon entering the workforce (Higgins et al. 2010; Kumaran and Carney 2014), competence (like cultural competence) is not static but a dynamic developmental activity (Lima et al. 2016). Registration is only the beginning of a life-long learning experience for nurses and NQNs need support to develop their confidence and competence after commencing employment through mentorship and, or a period of preceptorship or equivalent (Roberts and Johnson 2009; Holland

et al. 2010). Whilst a NQN is expected to be sufficiently competent upon qualification, it is not unreasonable to expect that they would be some skill deficits requiring further development including CCPB (Waite and Calamaro 2009). As Whitehead et al. (2013) have argued, a NQN may be (clinically) competent upon qualification but they "*do not have the self-confidence to be an autonomous practitioner*" (Whitehead et al. 2013: 371).

Upon commencing employment, NQNs report feeling overwhelmed by expectations (Andersson and Edberg 2010; Rush et al. 2013; Whitehead et al. 2013), unprepared for the nursing role (Edwards et al. 2015) and lack of confidence (Feng and Tsai 2012). Also, stress (Higgins et al. 2010; Cubit and Ryan 2011) and doubt (Kramer et al. 2012) are commonly reported.

2.6.1 Support and the NQN in transition

In the UK, the NMC has strongly recommended that all new registrants have a period of preceptorship on commencing employment to facilitate effective transition from student to accountable practitioner (NMC 2006; DH 2010b) and practise in accordance with the NMC Code (NMC 2015). The NMC recommend a formal period of "*about four months but this may vary according to individual need and local circumstances*" (NMC 2006: 2).

This is not considered a framework to address deficits in education but rather a 'model of enhancement' (NMC 2006; DH 2010b), clearly linked to the continued professional development of the nurse and subsequently reinforced in 2010 with the introduction of the UK Preceptorship Framework

for Newly Registered Nurses, Midwives and Allied Health Professionals (DH 2010b). This updated framework sought to revitalise the preceptorship approach within the NHS and demonstrated a commitment to staff and supporting improvement in patient care as required by the NHS Constitution (2015). However, this guidance (DH 2010b) was very clear that the four months advocated in the NMC Guidance (2006) was not sufficient to support effective transition for NQNs.

In the UK, preceptorship occurs post registration, however other countries notably the US and Canada, provide preceptorship for final year student nurses (Robinson and Griffiths 2009; Currie and Watts 2012; Cubit and Ryan, 2011). Whilst the one-to-one model of mentorship predominates in the UK, other countries have adopted a group or peer approach which has been shown to have a positive impact on retention (Figueroa et al. 2013; Hunsberger et al. 2013). This approach may well offer an alternative model for supporting NQNs during transition within the UK and address some of the challenges in ensuring consistent preceptorship support (Adams and Gillman 2017).

Both preceptors and NQNs agree that this period of supported learning facilitates the competence and confidence of the NQN so that they can practise independently and be a role model to other novices (Whitehead et al. 2013; Rush et al. 2013). However, despite this wealth of evidence as to the importance of competence and confidence enhancement during this period, the DH (2010b) framework clearly had a different expectation of

NQNs namely that "*From the moment they are registered, practitioners are autonomous and accountable"* (DH 2010b: 10).

Supportive transition experiences are known to impact on job satisfaction and intention to stay (Rush et al. 2013; Phillips et al. 2013; 2014), although, there is little evidence of the impact of this in terms of patient outcomes or care quality (Robinson and Griffiths 2009). The DH (2010b) have assumed that increased job satisfaction will impact positively on patient satisfaction. In addition, a lack of available or suitably qualified preceptors in the UK may have compromised the integrity of the one-one model of support (Deasy et al. 2011; Whitehead et al. 2013). As there was no mandatory requirement for employing organisations in the UK to ensure that preceptorship was provided and "*no formal qualifications associated with being a preceptor*" (NMC 2006: 3), preparation for the role and mechanisms available to support implementation have varied considerably (Currie and Watts 2012).

Adams and Gillman's (2017) systematic review of strategies for successful transition recommended three key features; support, socialisation and facilitated learning opportunities. Similarly, Rejon and Watts (2014), in their evidence review of strategies to support socialisation of nurses adopted Dinmohammadi et al.'s (2013) four key attributes; learning, interaction, development and adaptation. These feature in policy guidance (DH 2010b) and are similar to those cited in systematic or integrative reviews of transition experiences (Higgins et al. 2010; Rush et al. 2013; Whitehead et al. 2013; Murray-Parahi et al. 2016). There are differences in the focus in these

reviews, for example, Whitehead et al. (2013) were concerned with preceptorship and preceptors, whereas Rush et al. (2013) and Adams and Gillman (2017) explored the range of transition support programmes and approaches. However, all appear to be in agreement regarding the importance of support to facilitate practical skill development and the importance of a positive workplace culture that encouraged learning.

Whilst none of these studies specifically explored CCPB, their key findings are applicable and transferable to understanding development of this area of practice during transition. This is because the development of CCPB is also predicated upon the need for supportive organisations, positive role models and facilitated learning opportunities to enhance practice (O'Mara and Richter 2006; Douglas et al. 2014).

Studies that have looked at NQNs and CCPB have almost exclusively focused on the cultural competence of the preceptor or supervisor which has been considered critical to the efficacy of the supervisory experience (Burkard, et al. 2006; Constantine and Sue 2007; Dressel et al. 2007) as it facilitates open discussion about cultural issues and strengthens the supervisee - supervisor relationship (Burkard et al.2006; Dressel, et al. 2007). The converse is also true (Constantine and Sue 2007; Dressel et al. 2007).

However, whilst this relationship offers some insight into the development of CCPB, the focus has been on the relationship rather than on the skills or

competencies of CCPB. In addition, focus on the preceptor – NQN relationship has failed to consider social, cultural, environmental and organisational factors that mediate the relationship and learning experience. Research has therefore not addressed the impact of all variables in conjunction or considered what factors in addition to supervisor cultural competence influence effective translation into positive behaviours and practice.

2.6.2 Socialisation during transition

Becoming effectively socialised is an important element of the transition experience for NQNs (Adams and Gillman 2017). Socialisation can be seen as a process that occurs throughout life beginning in childhood with the learning of the roles, norms and culture into which one is born and this is part of identity formation (Cruess et al. 2015). Professional socialisation however refers specifically to the development of identity related to a particular occupation or role in which the skills, knowledge, beliefs and values of that profession are developed and internalised (Dinmohammadi et al. 2013).

Three key areas are considered relevant to the formation of professional identity; individual identity (personal characteristics and beliefs about oneself), relational identity (influence of significant others including family, peers and friends) and collective identity (social or professional groups to which the person belongs or wishes to belong) (Cruess et al. 2015). The development of a nurse's professional identity represents a complex interplay

of these three domains and the degree to which an individual identifies with the profession of nursing and defines themselves as ‘nurse’ is initially influenced by learning and experiences within educational settings. Acquisition of the values, beliefs and cultural norms of the (professional) group is not static, it is dynamic and influenced by interaction with others (patients, peers and other healthcare professionals) (Price 2009; ten Hoeve et al. 2014).

Professional socialisation is a process that varies from person to person and is not necessarily linear as the integration of this new identity requires change and adaptation and is continually renewed as part of life-long learning (Dinmohammadi et al. 2013). For some, this new collective identity may require reconstructing personal (individual and relational) identity to internalise the new role (Cruess et al. 2015). The situated learning that occurs within pre-qualifying education and practice (Lave and Wenger 1991) continues throughout the transition period and NQNs are keen to become a team member and be part of the professional practice community (Andersson and Edberg 2010; Rush et al. 2013; Phillips et al. 2013; 2015; Adams and Gillman 2017). Understanding the values of the organisation and gaining acceptance by colleagues were “*determinants of effective socialisation*” (Phillips et al. 2015: 120). Professional and organisational socialisation facilitates a smooth transition from the periphery of the ‘community of practice’ (CoP) (Wilson and Myers, 2000) as novice (Benner 1984), gravitating towards its center learning the values, norms and behaviours of

the profession and finally acquiring the professional identity of ‘nurse’ (Higgins et al. 2010; Whitehead et al. 2013).

Rejon and Watts (2014) noted that although organisations focus on formal learning opportunities for staff, up to 80% of learning within healthcare organisations is informal. The explicit codes of professional practice and behaviour are learnt as well as the ‘unwritten’ and ‘invisible’ rules or informal workplace practices determined by the majority or leadership group within the organisation (Husband and Hoffman 2009). The organisational culture of the workplace may or may not be supportive of the development of CCPB and as NQNs become active and engaged members of this communities, they increasingly act in accordance with the ‘community of practice’ (CoP) and their norms and customs (Lave and Wenger 1991). This process of becoming acclimatised to the CoP and workplace norms through a process of socialisation (Wilson and Myers 2000) necessitates discarding the student identity and status (Kumaran and Carney 2014) as they transition into the new environment (Curtis et al. 2012; Bray et al. 2013).

The importance of professional socialisation as part of the transition experience is ubiquitous throughout the evidence base (Rush et al. 2013; Phillips et al. 2013; 2014), is applicable across healthcare settings (Whitehead et al. 2013; Murray-Parahi et al. 2016) and to other professional groups (Green and Gates 2014). The relevance of the workplace culture to successful transition has been repeatedly emphasised (Higgins et al. 2010; Rush et al. 2013). Rejon and Watts (2014) reported that “*attitudes and values*

within a team are an important component of socialisation" (Rejon and Watts 2014: 6) but concluded that positive behaviours in the workplace were associated with staff perceptions of fairness of the organisational as a whole as well as immediate managers.

Also exploring organisational culture, Numminen et al.'s (2015b) multivariate analysis of 318 NQNs reported that perceptions of competence, empowerment and commitment to the organisation were influenced by the ethical climate of the practice environment. Organisational cultures which were characterised by professional sabotage (poor role models, covert and invisible rules and low support) and organisational sabotage (workload, staff shortages, time pressures and other constraints) have been shown to undermine successful transition into the workplace (Maben et al. 2006). Arguably, an ethical practice climate that is culturally competent as defined by Cross et al (1989), Betancourt (2003) and Loftin et al. (2013) would effectively support NQNs in the development of their CCPB. The skills acquired during educational preparation would develop incrementally (Teal and Street 2009) with further training (Gallagher and Polanin 2015) and a supporting workplace culture (Rush et al. 2013) embeds the 'knowing how' (Wilson and Myers 2000) of CCPB.

2.6.3 NQNs and the 'journey' of transition

The wealth of research exploring transition served to emphasise the importance of this period of time to NQNs. The enduring significance of what

Kramer's (1974) first described as reality shock, then Duchscher (2009) reframed as 'reality shock' is a consistent feature of models and literature in this area. The dissonance between the nursing ideals as taught, and the reality of working practice has suggested a complex process of adjustment and a sense of fear and uncertainty brought about by changed role and responsibilities and this was particularly stressful in the first few months (Gerrish 2000; Higgins et al. 2010). Benner's (1984) from 'novice to expert' model in which the nurse passes through five levels (novice, advanced beginner, competent, proficient and the 'expert') has shaped much of the earlier work in this field. Key to this model was the notion of stages achieved via education and experience in clinical practice over a period of time and consistent with the idea of continuous professional development in nursing and graduated competencies (NMC 2010).

Subsequently further research has helped to inform understanding of transition and supported the idea of stages in this process. Dearmun's (2000) longitudinal qualitative study of paediatric nurses proposed that the journey comprised four main stages; from initiation (1–3 months) to consolidation (around 6 months) to out-growing the role at 6-12 months and finally promotion vs. stagnation in the period beyond 12 months. However, these stages may well have reflected methodological choices as the time periods of the changes in this study seemingly reflect when data was collected (every three months since qualification). In Evans's (2001) focus group study of nine NQNs three main stages were reported; separation from student status, transition to staff nurse status and integration into the profession. However,

no timeframes were applied to these stages and as the data was collected at only one point post qualification, the model is not substantiated by the evidence provided and would require further research to validate the findings. Duchscher's study (2008) however provided rich data on the role transition of 14 nurses combining face-to-face interviews (at 1, 3, 6, 9, 12 and 18 months) with pre-interview questionnaires, monthly journals and focus groups. This research generated a model focused on personal and professional development and proposed three main stages within a twelve month timeframe; 'doing' (3–4 months),' being' (4–9) months and ' knowing' (8–12 months). Although this Canadian study allocated broad timescales to the stages, these were not necessarily linear and a robust methodology and multiple sources of data added validity to this model of 'becoming'.

Andersson and Edberg, (2010) offered a simpler model characterised by two key constructs; being a "rookie" (6–12 months) and becoming a genuine nurse (6–18 months). They did however conclude that there was a period of overlapping between these two during the six to twelve month period which took into account individual differences in the transition experience. However, this study interviewed only 8 nurses at one data collection point (one year post qualification) and was therefore reliant on recollection of the transition experience and potentially retrospective bias.

Whilst the aforementioned studies have proposed broad timescales for the stages, there is significant variation in terms of the length of time before 'expert' status (Benner 1984) was achieved. However, all were generally

longer than that of the four months recommended by the NMC (2006). In addition, the quality of research that has specifically explored stages is inconsistent and over-reliant on small scale, qualitative studies conducted in one location which limits their wider applicability without further research.

Studies in which data was collected at one point during the post-qualifying year do not offer the most robust perspective on transition and are reliant on retrospective accounts of experiences (Lewis and McNaughton Nicolls 2014). Studies have also tended to focus on individual experiences of transition or developmental and clinical competencies or organisational factors rather than offer an integrated perspective (with the exception of Numminen et al. 2015a). Pre-post studies such as Duchscher's (2008) inform understanding of the NQNs transition experiences at the point of qualification to that of fully autonomous practitioner and throughout, thus exploring the relationship between the identities of student and nurse and the transformation process in more detail.

Despite 'transition shock (Duchscher 2009) and the consistently reported experience of stress (Higgins et al. 2010; Cubit and Ryan 2011), there are significant gains in competence during the first six months. Lima et al.'s (2016) longitudinal study of competence found substantive and statistically significant gains in the first six months. Although there was stabilisation in the subsequent six to twelve month period, these did not achieve statistical significance resulting in the authors concluding that the first six months were the most important. Dearnum (2000) identified a 'psychological shift' in the

attitude of the NQN during this period as they became more confident and accountable for their actions. In Benner's (1984) model the competent stage is generally reached after two or three years in the same role or job and this would appear inconsistent with the clinical experience of NQNs in Lima et al.'s (2016) or the NMC expectations of graduate competencies (NMC 2014).

In addition, Gerrish (2000) comparative grounded theory study of two groups of NQNs (thirteen years apart, 1985 and 1998) concluded although NQNs were still 'fumbling along' contemporary transition experiences were less stressful and NQN's were better prepared with more active learning strategies. Since Gerrish's (2000) study, educational preparation for nurses has undergone substantive change and in addition, roles, responsibilities and the workplace settings in which NQNs practice have also experienced transformation (Lima et al. 2016) and will continue to do so. Consequently, the transition experiences that informed Benner's model (1984) may not necessarily be transferable, relevant or applicable to the experiences of NQNs practising in contemporary healthcare settings. However, this argument could equally be applied to all other models.

The notion of a model and stages does however remain relevant to understanding transition, but arguably requires reconsideration to better reflect the experiences of contemporary nurses. In addition, there appears to be an over reliance on acute sector experiences to inform understanding of transition (Murray-Parahi et al. 2016). Future models would therefore need to consider the challenges of transition within new and emerging workplace

environments that are more likely to be community based or located within non-NHS settings.

Whilst not exploring transition in NQNs, Meleis et al.'s (2000) middle-range theory offered an additional understanding of transition as it explored the nature of transition, transition conditions (facilitators and inhibitors) and patterns of response to the experience. One of the strengths of this model was that it synthesised previous work on transition and developed and extended this informed by five qualitative studies that used a transition framework. However, this was developed in the US and its applicability to the UK nursing transition experience should not be assumed. Some of the key concepts identified by Meleis et al. (2000) were too diverse and not applicable to the context, role and person specificity of this UK study. In addition, the model was informed by and developed from research into transition experiences of patients rather than examining professional roles and transition. The importance of professional role socialisation in relation to transition was discussed in the previous section and Meleis et al.'s (2000) model does not account for this important component.

Therefore, whilst models do exist that support research into transition, the research underpinning these theories reflected the transition experiences of cohorts of nursing students *at the time of the research* rather than offering a contemporary perspective. Educational preparation and workplace experiences of contemporary nurses are now significantly different and

transition models warrant further research and development to better reflect the uniqueness of NQNs experiences.

2.7 Conclusion

With an increasingly diverse patient population accessing healthcare both in the UK and internationally, the future nursing workforce must develop the skills and competencies to deliver high quality care to all irrespective of background. Educational preparation may have afforded NQNs sufficient opportunities to develop some but not all of the skills and behaviours required in the Code (NMC 2015) or considered pertinent to CCPB (Douglas et al. 2014). Professional guidance in relation to respecting individual differences and valuing diversity has tended to be primarily prescriptive without clear statements on what doing actually 'looks like' in practice. What healthcare providers, professional bodies and academics mean by sufficiently skilled in terms of CCPB has tended to focus on the polemic rather than the pragmatic.

Cultural competence as a concept has evolved over time and continues to change, and research to date has tended to focus primarily on race, ethnicity and, or religion rather than the nine 'protected characteristics' described in the UK equalities legislation. Whilst race, ethnicity and, or religion are evidently relevant to understanding CCPB, it would be erroneous to understand the application of this to contemporary nursing practice purely in these terms. CCPB is therefore an opportunity to improve the quality of

healthcare delivery (Zhao et al. 2016) and there is a need to re-examine this within the contemporary legislative framework and provide new insights into this phenomena that is relevant to current healthcare practice in the UK.

In addition, whilst studies of transition in NQNs are abundant, none specifically explore CCPB despite the significance of this for the patient experience, health outcomes and care quality. The transition period offers a unique phase in which to understand CCPB as NQNs undergo personal and professional development and socialisation and competence and confidence is enhanced.

Chapter 3: The Literature review

3.1 Introduction

In order to undertake this review, it was necessary to design and develop an explicit search strategy with the aim of producing a set of comprehensive and unbiased outputs that were relevant to the question under review. It can be seen from Section 3.2.1 (below) that a number of systematic reviews had already been conducted in relation to the two key topic areas relevant to this study (transition and NQNs, and cultural competence). It was considered inappropriate to replicate existing work and therefore, relevant literature and systematic reviews on these two core topic areas were incorporated into the background and context for the study (see Chapter two, Sections 2.5 and 2.6).

This first part of this chapter will provide an overview of the approach taken to review the literature specifically exploring NQNs *and* CCPB, detailing the search strategies used and the key papers identified. The second part of the chapter will focus on the key messages and themes arising from the papers identified in the review and identify gaps in the current evidence and knowledge base.

3.2 The literature review methods

Whilst the literature review search cannot be described as a full systematic review methodology (Machi 2009), a systematised approach using the key

principles advocated by systematic review guidance and integrative review (IR) methods (Whittemore and Knafl 2005) was used to focus the search, address issues of sensitivity and specificity and ensure that relevant literature was surfaced (Aveyard 2010). Whilst IR methods facilitate the inclusion of a range of different methodologies and is advocated in nursing research, there are limitations that can undermine rigour and accuracy (Whittemore and Knafl 2005). These are discussed in section 7.7 (study limitations).

The principles of IR and the five key stages as recommended by Whittemore and Knafl (2005) were used; these are identifying the problem or issue, literature search, evaluation, analysis and presentation.

3.2.1 Identifying the problem or issue

This review approach focused on identifying relevant primary research that would contextualise and inform the development of the study, ensuring a clear perspective on the key issues relevant to CCPB and NQNs. Database searching should be robust and justified, with an approach taken that balances sensitivity (locating all sources) with specificity (locating only relevant studies) (Aveyard 2010). As a precursor to undertaking the literature review and in accordance with systemic review guidance (Centre for Reviews and Dissemination (CRD) 2008) a preliminary examination was undertaken to ascertain if reviews had been undertaken or were taking place and to assist in the clarification of appropriate and relevant search terms. The

following databases and, or data sources were examined during 2013-4 and re-checked in 2015 to facilitate this;

- The Cochrane Database of Systematic Reviews (CDSR)
- Database of Abstracts of Reviews of Effects (DARE) including Health Technology Assessment (HTA) programme and NHS Economic Evaluation Database (EED)
- The National Institute for Health and Clinical Excellence (NICE)
- NIHR Health Technology Assessment (NIHR HTA) programme websites.
- The Campbell Collaboration
- The Evidence for Policy and Practice Information (EPPI) Centre (including Database of Promoting Health Effectiveness Reviews (DoPHER), Trials Register of Promoting Health Interventions (TRoPHI), Database of education research and Current Educational Research in the United Kingdom (CERUK))

These were examined to facilitate the clarification of appropriate search, thesaurus and MESH terms as well as surfacing cultural differences in the use of terminology between the UK and internationally prior to searching via databases. This revealed four reviews that were potentially relevant to the study subject focus of CCPB;

1. Horvat, L., Horey, D., Panayiota, R, and Kis-Rigo, J. (2014) Cultural competence education for health professionals. Cochrane Database of Systematic Reviews, Issue 5. DOI:10.1002/14651858.CD009405.pub2
2. Truong M; Yin Paradies Y and Naomi Priest N (2014) Interventions to improve cultural competency in healthcare: a systematic review of reviews. BMC Health Services Research 2014 14:99.
3. Lie DA, Lee-Rey E, Gomez A, Bereknyei S, Braddock CH (2011). Does cultural competency training of health professionals improve patient outcomes? A systematic review and proposed algorithm for future research Journal of General Internal Medicine 2011; 26(3): 317-325
4. Beach MC, Price EG, Gary TL, Robinson K, Gozu A, Palacio A, Smarth C, Jenckes M, Feuerstein C, Bass EB, Powe NR, Cooper LA: Cultural competence: A systematic review of health care provider educational interventions. Med Care 2005, 43:356–373.

In addition, five systematic or integrative reviews were identified in relation to NQNs and transition;

1. Adams JE and Gillman L (2017) Developing an evidence-based transition programme for graduate nurses. Contemporary Nurse, 52 (5), 511-521
2. Murray-Parahi, P., Digiacomo, M., Jackson D and Davidson PM (2016) New graduate registered nurse transition into primary health

care roles: an integrative literature review. Journal of Clinical Nursing, 25, pp.3084–3101.

3. Whitehead, B., Owen P, Holmes D, Beddington E, Simmons M, Henshaw L, Barton M and Walker C (2013) Supporting newly qualified nurses in the UK: a systematic literature review. Nurse education today, 33(4), pp.370–7.
4. Rush, K.L. Adamack M, Gordon J and Meredith L (2013) Best practices of formal new graduate nurse transition programs: An integrative review. International Journal of Nursing Studies, 50(3), pp.345–356.
5. Higgins, G., Spencer, R.L. and Kane, R., 2010. A systematic review of the experiences and perceptions of the newly qualified nurse in the United Kingdom. Nurse Education Today, 30(6), pp.499–508.

Consistent with Whittemore and Knafl's approach, (2005) this preliminary scoping indicated that there was already a wealth of integrative and systematic reviews on cultural competence and, on the transition of NQNs, although no Cochrane reviews of transition in NQNs were found. As there were restrictions on time and resources, and consistent with the aim of the study it was determined appropriate that the review would focus on these core concepts (CCPB and NQNs) *in combination* as part of this review methodology. A specific search question was formulated to interrogate the literature in relation to the study aim and objectives and to assist in identifying and understanding the existing knowledge base to ascertain what was known and not known. This then informed the development of more

formal research questions as shown in chapter four (section 4.2). The question developed to inform this part of the study and consistent with the aim and preliminary objectives was: What are newly qualified nurses' key skills and, or behaviours in relation to the delivery of culturally competent nursing care?

3.2.2 Literature search

The search was conducted between July and October 2014 and then replicated in October 2016. The same methodology was used in both instances. This was conducted using EBSCO and the databases accessed were; Academic Search Premier, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, Psycarticles, PsychInfo and Index to Thesis. The key topic areas and related search terms were used as indicated below (where permitted);

Search Terms;

Population: Newly Qualified Nurse, OR Newly Registered Nurse OR Registrants OR Novices OR Nurses, OR Nurse **AND**

Intervention: Cultural competence OR cultural competency OR cultural diversity OR cultural diversities OR Transcultural nursing OR cultural safety OR cultural humility OR Cultural skill OR Cultural behaviour

Context: Healthcare, health provision, healthcare settings, healthcare practice

A free text strategy was used in databases without a well-constructed thesaurus and Medical Subject Headings (MeSH) were used for all others. The literature was searched using the above terms and these were combined to narrow the focus using Boolean logic which helped to more clearly define the relationship between words or groups of words using AND, OR. Truncation was used (also exp - explode) to ensure that all the relevant narrower terms were included. For example so that using the term exp. nurs will retrieve data relating to *nurse*, *nurses* and *nursing.* This was applied to title, abstract and keywords as part of the initial retrieval of papers and specific limiters to the search applied (see inclusion and exclusion criteria below).

When conducting a review, methodological decisions have to be made regarding inclusion and exclusion criteria and a rationale provided to justify the search method used (Hart 1998). Date parameters ensured that the review was able to focus on the identification of relevant contemporary literature. In accordance with that recommended by Truong et al. (2014) a pre date was set at 2000 to enable the capture of relevant papers post the introduction of government policy directing the inclusion of cultural competence in the US (as no comparable UK policy on cultural competence was available to inform the date parameter). This allowed for the capture of literature relevant to NQNs and transition following the reforms to nurse education in the UK (known as Project 2000).

In addition, papers were selected from only peer reviewed journals and, or those with impact factors. This was to ensure that only papers with suitable standards of quality and a high level of credibility were selected. The impact factor system provides a measure which expresses the critical evaluation of quality for research papers (Saha et al. 2003). Papers that are accepted in impact factored journals will also have been subject to the peer review process; another quality measure in published research and literature. This enabled the removal at the search stage of all, non-peer reviewed papers, editorials and anecdotal items that represented unreferenced opinion pieces as well as duplicates. The key inclusion and exclusion criteria are shown below in Text Box 1.

Inclusion criteria	Exclusion criteria
Articles published after 2000 (in line with Truong et al. 2014 systematic review)	Articles published before 2000
Published in the English language	Not in the English language
Articles from peer reviewed journals	Articles that were non peer reviewed papers
Primary or secondary research, systematic or integrative literature reviews	Editorials and, or commentary and opinion pieces
	Multiple reporting of the same study in different journals
NQNs, Nurses	Student Nurses

Patients not nurses	Patient diversity not CCPB of nurses
Nurses not NQNs but skills, behaviours and, or competencies of CCPB	Papers focused on only knowledge, awareness, sensitivity or any other aspects of cultural competence but did not describe skills, behaviours and / or competencies

Text Box 1: Inclusion and exclusion criteria

Secondary searching was also conducted as an adjunct to database searching. The previously identified systematic or integrative reviews on cultural competence and, or NQNs in transition were also examined. These were included if information relevant to skills and, or behaviours and, or competencies was included, or where disaggregated data was available that specifically addressed differences in terms of years of experience or length of time since qualification.

As an additional check to the validity of the search and screening process and to add further robustness, additional searching was conducted of relevant websites and journals and via reference lists. Websites searched were; The Royal College of Nursing (RCN), Equality and Human Rights Commission, The Nursing and Midwifery Council (NMC), The Department of Health (DH), Transcultural Nursing Association, and the European Transcultural Nursing Association. Journals included; The International Journal of Nursing Studies, British Medical Journal (BMJ), The Journal of Advanced Nursing (JAN), Nurse Education And Practice (NEP), Journal of

Transcultural Nursing, Diversity and Equality in Health and Care and, Ethnicity and Inequalities in Health and Social Care.

A final additional search using cultural competence and skills, cultural competence and NQNs was also undertaken using Google Scholar as an additional check to the search. An author search was also conducted of commonly cited authors in the field of cultural competence to further identify potentially relevant papers. This was undertaken as an adjunct to the review process described above and as a further check to the validity of the search and screening approaches (Whittemore and Knafl 2005; Aveyard, 2010).

From this combined search 237 potential papers were identified. Titles and keywords were searched and any duplicates identified across the databases were removed (n=57). The abstracts of the remaining articles (n=180) were then examined manually to determine relevance to the review question and suitability based on the inclusion and exclusion criteria. Those that did not meet the inclusion criteria were excluded. All papers were removed if they focused on education or student nurses (i.e. not NQNs). At this stage, a paper was included if it focused on nurses (not NQNs) if, and only if, it described skills, behaviours and, or competencies. This resulted in the removal of 147 papers leaving 33 papers for full screening (see PRISMA flow diagram in Appendix 2).

The full text articles of the 33 papers were retrieved and full screening for eligibility was undertaken.

3.2.3 Data evaluation stage

Determining the quality of the sources retrieved is key to the data evaluation stage. The review criteria focused on the study aim or purpose, type of study e.g. design, sample, methods of data collection and approach to analysis, key results, strengths and limitations. CASP (Critical Appraisal Skills Programme) tools were used to guide this stage and all papers were thoroughly scrutinised and papers were selected based on subject, content and relevance to the principal question posed for the literature review. 26 further papers were then removed because they were found to focus only on student nurses, or if focused on both students and qualified nurses did not provide data on length of time since qualification or years of experience. Therefore it was not possible to disaggregate the findings to use only data relevant to NQNs. As with the screening stage, papers were included if they specifically addressed the issue of skills, behaviours and, or competencies in relation to CCPB and were focused on nurses and, or, nursing. Papers were however excluded if they referred to skills, behaviours and, or competencies but provided no description, text or examples.

The remaining 7 papers are summarised in Appendix 3 and details are also provided of all the papers excluded (n=26) and a rationale provided as to the reason for exclusion.

3.2.4 Data analysis stage

The data analysis stage requires the extraction of key data from the included papers and ordering of this so that the review question could be addressed. Preliminary categorisation was undertaken to determine strengths and weaknesses in relation to each of the papers and detail key findings from the studies. The papers were assigned to either a), factors relevant to NQNs and the development of CCPB or b), key characteristics of skills and, or behaviours of CCPB. Within these broad categories, subthemes were generated based on key findings.

3.2.5 Review presentation stage

The final stage in Whittemore and Knafl's (2005) process is data presentation and to address this stage sufficient detail is provided of the review sources to support the conclusion generated from the review. This final synthesis is presented in a narrative format and reflects upon and discusses the key findings of the review in terms of NQNs and CCPB and the behaviour, skills and competencies relevant to their development during this period. This is shown in Section 3.3 below.

3.2.6 Overview of studies

Of the final 7 papers included in this review, 3 studies specifically explored CCPB and NQNs. Two of these studies used quantitative methodologies

including a cross sectional survey of 71 NQNs (Lampley et al., 2008), and a self-report survey of 126 registered nurses (Songwathana and Siriphan 2015). A further study by Hagman (2007) was an exploratory qualitative study of 66 RNs using text-based responses from a questionnaire as part of a larger study (not included).

For all remaining studies, information was extracted that specifically examined the key characteristics of skills and, or behaviours of CCPB. These studies included a Delphi study of twenty four experts (nurses, researchers and lecturers) (Jirwe et al., 2009), a concept analysis (Cai 2016), a vignette (Campinha-Bacote 2011) and a systematic review (Horvat et al., 2014). Of the available systematic or literature reviews on NQNs and transition, none specifically explored CCPB and thus were not included in the final analysis review.

There was considerable variation in terms of the quality of the papers finally included with different methodological approaches creating challenges for data integration and synthesis. This difficulty has been reported in other systematic reviews (Horvat et al., 2014, Truong et al., 2014, Lie et al., 2011, Beach et al., 2005). Overall the quality of the evidence generated ranged from poor to moderate, with methodological limitations evident in all the published work. Three of the studies were conducted in the US (Hagman 2007; Lampley et al., 2008; Campinha-Bacote, 2011), with one conducted in Sweden (Jirwe et al., 2009) and one in Thailand (Songwathana and Siriphan

2015). The remaining two papers (Cai 2016; Horvat et al., 2014) were a concept analysis of cultural competence and a Cochrane systematic review so were not location specific.

Only four of the papers reported research findings (Songwathana and Siriphan 2015; Jirwe et al., 2009; Lampley et al., 2008; Hagman 2007). The included paper by Campinha-Bacote (2011) although described as a vignette was not used as a research methodology (Hughes and Huby 2004), and would be better described as a case study or best practice exemplar. The paper, did however include specific descriptions of the skills related to cultural competence. Sample sizes in the studies ranged from 66 to 126 and convenience sampling was common with the exception of Songwathana and Siriphan (2015) who used stratified random sampling. Different tools were used to capture data including the 8 item demographic survey developed by research team in conjunction with the IAPCC (Lampley et al., 2008), a self-report questionnaire on Cultural competency developed from the Campinha-Bacote's (2002) model (Songwathana and Siriphan 2015).

3.3 Key themes

Following appraisal of the papers a number of key themes emerged relevant to understanding CCPB in NQNs. Preliminary notes were initially captured in an additional column in the study characteristics table (see Appendix 3). The following subthemes emerged in relation to the two main categories; i) length

of years in practice, education and further training, ii) the cultural encounter, cultural assessment and the personal qualities of the nurse. Communication was a cross-cutting theme throughout ii).

3.3.1 Experience and length of years in practice

Number of years in nursing practice was seen as a key factor in the development of CCPB (Hagman 2007; Lampley et al. 2008). Lampley et al., (2008) reported significant differences between the years of nursing experience with participants with 1 to 5 years of experience achieving lower scores (*M* = 50.47, *SD* = 6.06) on the IAPCC than those with more than 20 years (*M* = 57.11, *SD* = 6.50). Similarly, Hagman (2007) exploratory study of 66 RN's reported a positive association between age and number of years although no data was provided to evidence this except reference to a previous study (Hagman 2006). However, in this aforementioned paper no data was provided on years as RN and cultural self-efficacy scores to evidence this.

However, it is not clear whether years of experience (length of time) and that of number or frequency of encounters is important as neither Hagman (2007) nor Lampley et al. (2008) explored this. Songwathana and Siriphan (2015) found no differences in levels of cultural competence between 1 and >2 years nurses post qualification. However, the comparator group (>2 years qualified) was small (n=8) and the study highly localised.

In addition, although Lampley et al. (2008) reported differences in mean IAPCC scores for NQNs (novices) when comparted to more experienced nurses, both groups' mean scores were still in the culturally aware level (<1 year mean 51.45 SD 4.41, >20 years mean 57.11 SD 6.50) with ranges from 40 – 59. Consequently, although years of experience may be relevant to understanding CCPB, this does not necessarily result in the more experienced nurses achieving cultural competence or cultural proficiency as measured by the IAPCC.

3.3.2 Education and training

Education on cultural issues was considered important to the development of CCPB in the post-qualifying period, as was level of educational attainment. Lampley et al. (2008) found that IAPCC scores of participants receiving continuing education were significantly higher (M = 54.43, SD = 6.00) than those who did not (M = 50.63, SD = 6.09) and similarly, respondents in Hagman's (2007) study cited additional workshops and classes as enhancing levels of self-efficacy in cultural competence. However, 65.1% of the participants in Songwathana and Siriphan's (2015) study had not had additional training on multicultural care and yet their scores were in the moderate range for overall cultural competency (X=14.47 SD 1.940).

Although this study used a self-report questionnaire and piloted this for internal consistency, it has not been further tested to validate these findings in comparison to the IAPCC used in Lampley et al.'s (2008) study. In addition, as the participants in Songwathana and Siriphan's (2015) study were all from three provinces of Thailand with limited diversity in the general population, they were not representative of RNs in other countries.

Educational level was also implicated in increased cultural competence and Lampley et al. (2008) found participants had higher scores on the IAPCC when they had a master's degree (*M* = 58.89, *SD* = 6.60), compared to an associate's (*M* = 51.94, *SD* = 5.31) or bachelor's degree (*M* = 51.56, *SD* = 5.82). Knowledge of cultural identities should promote cultural understanding of the patient (Jirwe et al. 2009) and Songwathana and Siriphan (2015) reported that knowledge of cultural issues was at a moderate level in NQNs (X =2.21, SD =.531), despite their lack of experience in years. It may well be that further study in the form of a post-registration course or qualification may provide further opportunities for increasing knowledge and understanding of this area of practice. However, whilst Cai (2016) notes that knowledge can comprise 'do's' and 'don'ts' when interacting with patients from diverse backgrounds, Hagman (2007) challenges this advocating against knowledge as list of cultural facts.

Although the findings from Songwathana and Siriphan (2015) and Lampley et al. (2008) contradict each other, this may well reflect the specificity of the

studies in relation to location, the characteristics of the participants as well as the different measurement tools used. However, Lampley et al. (2008) would appear to be supported by Hagman's (2007) study, although substantive flaws in the reporting of the latter in terms of demographic data and analysis question the validity of the findings.

One of the strengths of Lampley et al.'s (2008) study was that it specifically used Benner's (1984) model of transition to interpret and relate the results to that of the model developed by Campinha-Bacote (2002). Novice was paired with the culturally incompetent range, advanced beginner with culturally aware, competent with culturally competent and proficient with culturally proficient. However, after more than 20 years of experience, the nurses in this study were still at the 'culturally aware' level. I would argue that after 20 years they should have achieved competent or proficient in Benner's (1984) model.

3.3.3 Skills, behaviours and competencies

NQNs in Songwathana and Siriphan's (2015) study were found to have self-reported moderate levels of cultural skill (X =2. 84, SD = .405) and these skills were specifically in relation to the communication encounter. Skill development via interaction with patients from diverse backgrounds was a prominent theme throughout the papers. This provided an opportunity for the nurse to understand and learn about the cultural context of the patient

(Hagman 2007; Campinha-Bacote 2011), and demonstrate respect for the individual patient, their perceptions, values, beliefs, health preferences, life situation and background (Jirwe et al. 2009; Lampley et al. 2008).

Actively listening to the patient or client (Jirwe et al. 2009; Songwathana and Siriphan 2015; Hagman 2007), was seen as part of the repertoire of the interpersonal skills of the healthcare professional (Horvat et al. 2014). Similarly, listening to others and assessing ideas, beliefs and values of clients were the highest reported scores in Songwathana and Siriphan's (2015) study (X = 3.28, SD = .776, X = 3.01, SD = .701 respectively) and Hagman's (2007) identified the importance of listening, observing and asking questions as key to a mutually appreciative encounter.

The cultural encounter was considered a necessary antecedent to the development of cultural competence in the multi-component model proposed in Cai's (2016) concept analysis. However in Jirwe et al.'s (2009) Delphi study of 24 experts (8 nurses, 8 researchers and 8 lecturers) cultural encounters comprised four core components. First an awareness of the influencing factors, which was not dissimilar to that of cultural self-assessment reported by Horvat et al. (2014). Secondly, skills in cultural encounters such as demonstrating respect, interest and that 'one wants to respond to the patients' cultural needs' (Jirwe et al. 2009: 2628) and can be considered similar to cultural desire in both Cai's (2016) and Campinha-Bacote's (2011) model.

The remaining two components in Jirwe et al. (2009) study were focused on communication; communication (verbal and non-verbal) and cultural differences, and language awareness and communication challenges. Verbal and nonverbal communication skills appropriate to the individual patient were illustrated in the vignette provided by Campinha-Bacote (2011) and included an awareness of cultural differences (Jirwe et al. 2009; Lampley et al. 2008). Hagman (2007) recognised that there can be dissonance between patients' and nurses' interpretation of a communication event due to cultural differences and this could lead to misunderstanding potentially impacted upon nurse-patient trust (Jirwe et al. 2009).

In the vignette provided by Campinha-Bacote (2011), the nurses' skills were demonstrated by communicating throughout the cultural assessment. The assessment was described by Cai (2016) as collecting "*relevant cultural data on the clients current health problem*" (Cai 2016: 270) and this included assessing the patients language skills and preferred language (Jirwe et al. 2009), 'asking questions' of the patient (Hagman 2007) and assessing ideas, beliefs and values of the patient (Songwathana and Siriphan 2015). Both verbal and non-verbal communication skills were considered essential to undertake a cultural assessment (Campinha-Bacote 2011; Horvat et al., 2014; Cai 2016).

The challenge of caring for a patient from a diverse background when there is no shared language was emphasised to an extent in all the studies

included. Jirwe et al. (2009) specifically cited a nursing skill was knowing when an interpreter was needed in addition to being skilled in communicating with a patient via this method and this was similarly reported by Cai (2016). Whilst some of the papers were specifically concerned with the challenges of communicating when language proficiency was not shared (Hagman 2007; Lampley et al. 2008), others were more focused on what constituted exemplary inter and intra personal skills of the health professional necessary to establish trust and partnership working (Jirwe et al. 2008; Horvat et al. 2014).

The personal qualities of the nurses including intra-personal skills such as cultural self-assessment, reflective practice, and an ability to deconstruct stereotypes (Horvat et al. 2014). These skills are consistent with the notion of cultural humility (Foronda et al. 2015) or awareness (Papadopolous et al. 2016). Similarly, Jirwe et al. (2009) considered cultural sensitivity as a precursor to culturally appropriate care and this necessarily involved cultural self-assessment to identify bias, stereotypical assumptions and potentially ethnocentric worldviews. Although personal experiences of diversity (background) are commonly cited as important for the development of cultural competence in the general literature, Lampley et al. (2008) found that neither race nor gender appeared to have a significant influence on levels of cultural competence.

The participants in Jirwe et al.'s (2009) Delphi study considered that some of the qualities proposed were generic (core) nursing qualities and attributes (for example empathy, compassion, respect, openness). That is, they were not exclusive to CCPB.

3.4 Conclusion and identification of key gaps in the evidence base

In conclusion, the literature review has identified a number of key issues and gaps in the evidence base that warrant further investigation. There has been little attempt within UK healthcare provision to ascertain whether educational preparation successfully translates into CCPBs following completion of an approved programme. This review has identified that research has tended to focus on the student population and curriculum and programme delivery in terms of impact or on experienced nurses (experts according to Benner's (1984) model). However, the lack of available research evidence that specifically addresses CCPB in NQNs would lend support to the argument that this is underexplored in the literature and represents a distinct and unique topic area.

Explicit examination of the skills and behaviour required by nurses to successfully demonstrate these skills in practice warrants further investigation as much of the literature in this area is focused on sensitivity, awareness and knowledge components of cultural competence. Whilst there

is a wealth of papers that refer to skills and, or behaviours (in keywords and abstracts) they invariably do not provide any information or detail as to what those skills actually are. This deficit in information is supported by Horvat et al.'s (2014) Cochrane Review.

In addition, there is a tendency for author(s) to replicate and, or recycle common descriptors of skills using for example 'cultural skill is the application of the knowledge, awareness, sensitivity to the cultural encounter' (Campinha-Bacote 2002). This consequently does not describe the skill or illustrate what this might look like in terms of application to everyday nursing practice. Similarly, the NMC Code (2015) is predominantly prescriptive in relation to relevant statements such as recognising diversity. This study seeks to move beyond the current evidence base which is predominantly prescriptive, informing nurses of what they should do and move towards easily understood behavioural descriptors that illustrate what doing looks like. Generating tangible examples of CCPBs is not only important and necessary to ensure the delivery of culturally competent care but also relevant to the wider debate within the UK NHS on the need to deliver values based care centred on compassion, dignity and respect.

In addition, NQNs are a unique and particularly relevant group to study in relation to this topic area in the UK. Having recently completed a pre-registration nursing programme, they have benefited from educational input that is reflective of the nine 'protected characteristics' detailed in the UK equalities legislation. Their views and experiences therefore offer a

contemporary perspective on CCPB and on the skills and behaviours required to develop and demonstrate this in today's healthcare settings. As NQNs enter the workplace, knowledge and practice skills are enhanced and embedded. This is a period of accelerated learning, development and professional socialisation providing a unique timeframe in which to explore and understand their perceptions of CCPB.

Chapter 4: Study philosophy, methodology and design

4.1 Introduction

It can be seen from the literature discussed in chapters two and three that whilst there was a significant amount of research in the field of cultural competence and in that of NQNs and transition, there were gaps in the current evidence base. These gaps subsequently informed the research questions, the study philosophy, methodology and design. This chapter commences by specifying the main study research questions and provides a rationale underpinning the choice of questions. Then, the philosophical and methodological perspectives that framed the study are discussed including a justification for an interpretative approach framed by symbolic interactionism (SI). The final part of this chapter discusses the study design, sample, inclusion and exclusion criteria and the data collection methods used. The final part of the chapter addresses issues of trustworthiness, credibility and transferability.

4.2 Study aim and research questions

Qualitative enquiry is necessarily underpinned by a reflective iterative process in which the study evolves and is shaped by the insights, knowledge and experience of engaging in the research process (Cresswell 1989) and this can include during data collection (Agee 2009). Thus, the study's overarching aim and objectives (see Section 1.2) evolved via a process of

engaging in the research process and specifically undertaking the literature review.

The aim of the study was formalised into six specific research questions as indicated below;

1. What are NQNs experiences of engaging with patients from diverse backgrounds following registration and commencement of employment? (Objective 1)
2. Have NQNs developed the skills and competencies to care for culturally diverse patients? (Objective 1)
3. Does NQNs cultural competence change (increase, decrease or stay the same) as they undergo the transition from novice to autonomous practitioner (Objective 2)
4. What are the skills and competencies of culturally competent practice behaviour? (Objective 2)
5. What (self-perceived) factors enable or facilitate the development of culturally competence practice behaviours as NQNs undergo transition from novice to autonomous practitioner? (Objective 3)
6. What (self-perceived) factors or limit or hinder the development of culturally competence practice behaviours as NQNs undergo transition from novice to autonomous practitioner? (Objective 3)

The last two questions and a supplementary objective (objective 3), emerged from a more informed understanding of the topic area, evidence base, literature review and theoretical perspectives (Marshall and Rossman 2011; Bryman 2012). Objective 3 was; to explore (self-perceived) factors that enable or facilitate, limit or hinder the development of cultural competent practice behaviour as NQNs undergo transition.

These questions therefore represented specific elements of the inquiry that warranted further investigation. Q's 1 and 2 determined whether NQNs had opportunities for engaging with patients from diverse backgrounds, that is, whether they experienced 'cultural encounters', and whether they perceived that they had developed skills and competencies. Whereas, Q's 3 and 4 focused on whether NQNs were able to give an account of skills, competencies and behaviours that constituted CCPB. This was linked to existing gaps in the evidence base as argued in Section 3.4 in order to generate further knowledge and insights into this area of nursing practice. The final two questions (5 and 6) were focused on understanding the personal, professional and organisational influences through which NQNs experiences of CCPB could be understood and interpreted. Specifically, these aimed to take into account those factors relevant to the generic transition experiences of NQNs as discussed in section 2.4 within the context of CCPB. Therefore, these questions in combination represented an attempt to address the deficits in the evidence base and consider CCPB with reference to the cultural encounter between NQN and patient within the context of contemporary healthcare settings.

4.3 Philosophical positioning

Philosophical exploration is a necessary and important precursor prior to specifying the research methods to be used and the type and ways in which data can be gathered (Easterby-Smith et al. 1997, Crotty 2003). Determining the relevant and appropriate philosophical starting point facilitates consistency, coherence and integrity throughout the study (Holden and Lynch 2004), although not all authors agree that this is necessary, useful or helpful in nursing research (Smith et al. 2011). Considering the philosophical paradigm necessitated deliberate judgements regarding the researcher's perspective on the nature of knowledge, reality, the world and the objects within it (Krauss 2005). The research paradigm to be adopted must consider to what extent the researcher can be said to be subjective (involved in, or has an influence on) the research outcome or objective (distanced from, or independent) in the execution of the fieldwork. Whilst this was an important consideration, equally relevant was the concern regarding philosophical or methodological 'straightjackets' which may well constrain researchers (Ormston et al. 2014).

As recommended by Easterby-Smith et al. (1997) and Crotty (2003) understanding the three main components of research paradigms; epistemology, ontology and methodology are essential for approaching research. Ontology (from the Greek word) 'being; that which is' and 'science, study, theory' deals with questions concerning what entities exist or can be said to exist and refers to the theoretical assumptions about what can be known. Epistemology (from the Greek word epistēmē meaning knowledge,

understanding) is the philosophy of knowledge or how we come to know and understand the world i.e. how knowledge is derived. Methodology is related to epistemology as it is also concerned with how we come to know and understand the world but it is focused on the pragmatics; the specific practice (or methods) that are used to try to understand the world.

Essentially, in order to consider the how of research (methodology), the why of research also requires deliberation. Positivist and phenomenological paradigms represent two of the principal approaches within which a study can be framed and the key features of these are shown below in Text box 2;

	Positivist paradigm	**Phenomenological paradigm**
Basic beliefs	The world is external and objective	The world is socially constructed and subjective
	Observer is independent	Observer is part of what observed
	Science is value-free	Science is driven by human interests
Researcher should	Focus on facts	Focus on meanings
	Look for causality and fundamental laws	Try to understand what is happening
	Reduce phenomenon to simplest elements	Look at the totality of each situation
	Formulate hypotheses and then test them	Develop ideas through induction from data
Preferred methods include	Operationalising concepts so that they can be measured	Using multiple methods to establish different views of phenomenon

	Taking large samples in depth or over time	Small samples investigated

Text box 2: Overview of positivist and phenomenological paradigms

(Easterby-Smith et al. 1991:2)

This overview of the two main paradigms provided a useful framework within which to consider where the study was most suitably aligned. As this study was primarily concerned with attempting to describe, explore and explain perceptions of CCPB and its meaning within a particular defined situation, this study was more suitably located within a phenomenological paradigm (Johnston et al. 2016). The nature of the phenomenon being explored has specific reference to NQNs subjective experience with the primary aim of soliciting perceptions of CCPB of the (human) participants in this study. This is underpinned by the epistemological assumption that the participants' individualistic and subjective constructions of CCPB can be communicated and these are available to another person i.e. the researcher.

Philosophical assumptions relating to knowledge and existence, the nature of 'being' and 'knowing' underpin these perspectives (Crotty, 2003). The philosophical stance assumed in this study draws on the rich historical phenomenological tradition, informed by the work of Husserl, Heidegger, Gadamer and Merleau-Ponty that has previously been used within nursing research (Dowling 2007; Earle 2010) to explore and value peoples' lived experience of a phenomenon (Balls 2009). Whilst a purist position can be assumed that is congruent with a particular strand of phenomenology

(Benzies and Allen 2001; Johnston et al. 2015) and exclusively aligned with either the descriptive tradition of Husserl, the interpretative approach of Heidegger or one of the many derivations (Matua and Van Der Wal 2015), it should be noted that their viewpoint was a way of 'doing philosophy' (Dowling 2017). Challenging the dominant positivist paradigm of the time, "*none of these philosophers made any attempt to develop a set of strict rules or procedures for conducting phenomenological research"* (Earle 2010: 267)*.* Arguably, the use of phenomenology as methodology, although derived from phenomenology as philosophy, represents a subjective interpretation of its application by scholars within this tradition.

Consequently, a distinction must be made between adherence to a particular phenomenological school or thought (and its resultant methodologies) or phenomenology as philosophical positioning. In this study, the positivist position was deemed unsuitable as human beings are not objects (Parahoo 2006). This was not necessarily a rejection of the positivist paradigm, its principles or approach rather an informed decision as to the appropriate alignment of the study. Given that the current state of the evidence base in relation to CCPB and NQNs was limited and beset by conceptual ambiguity, an exploratory qualitative investigation was needed that would surface practitioner generated descriptors of practice (Krauss 2005). The principal epistemological difference between the positivist position and that of the naturalist or constructive approach is that the positivist position is objectivist and characterised by the belief that it is possible for an observer to remain

detached and uninvolved whilst in the latter the inquirer and the inquired are intimately interlocked.

One of the strengths of using a phenomenological approach for this study was that it recognised that meaning regarding the topic was seen as constructed by people (the participants) as they interacted, engaged with and interpreted the world in which they were situated (Crotty 2003). The meaning of CCPB then was accessed "*through the subjective lens of the people experiencing it*" (Johnston et al. 2016: 575). This is thus a constructionist position. This can be assumed from an entirely and exclusively subjectivist position (as in idealism) however, this position does challenge our common sense view of the world. In approaching the study from this perspective, my position is more appropriately described as constructionist rather than constructivist. Constructionists recognise that meaning is constructed of and with reference to something; i.e. the world and the objects in it. Thus it is important to distinguish between a constructionist claim that relates to things or facts in and of themselves and those that relate to our beliefs about them (Hacking, 1999). The former can be seen as a metaphysical claim that something is real but that reality is of our creation. The latter can be considered an epistemic claim – the reason why we have some particular belief is related to the role that that belief plays in respect of our social selves, and is not necessarily related to evidence we have of it. This distinction was important in determining resultant methodology as constructivism focuses on internal constructs (mind or brains) whereas constructionism was concerned with social exchange and interchange.

However, constructionist viewpoints are not without their limitations (Lincoln and Guba 2000; Crotty 2003; McCance and Mcilfatrick 2008). Being accepting of multiple interpretations and viewpoints can lead to uncertainty and create challenges in generating explanatory accounts, trends or theories of human behaviour. However, whilst objectivism and subjectivism are often portrayed as polar opposites, or contrasting paradigms (Hunter 2008), researchers can assume a philosophical position somewhere along this continuum (Holden and Lynch 2004), or equally reject both or embrace both, as they can coexist (Krauss 2005). There is a traditional (positivist) assumption that the researcher must be completely independent in science (Easterby-Smith et al. 1991) however, the phenomenological approach not only rejects this assumption but values the contribution that the researcher perspective can bring (Earle 2010). The researcher is not independent or value-free and the researcher's own assumptions, views and background are a legitimate tool to use to interpret participant perceptions (Johnston et al. 2016).

In this study, assuming a position that was positivistic and (allegedly) value-free (Krauss 2005) was rejected in favour of a viewpoint informed by phenomenology. Although, the position assumed did not necessarily embrace the polar opposite end of the continuum (Lincoln and Guba 1985), the dichotomy is not rejected or replaced as in critical realism or variants of it (Krauss 2005; Hunter 2008) instead an 'empathic neutrality' is advocated (Ormston et al. 2014). That is, a position was adopted that supported the notion that research is and cannot be entirely value free (as in a 'true'

positivistic sense) but instead advocates for transparency of assumptions and potential biases throughout the research process consistent with the constructionist approach (Johnston et al. 2016). Central to this position is the notion of reflexivity.

4.4 Reflexivity within this study

Reflexivity within the context of nursing research can be seen as "*the process of a continual internal dialogue and critical self-evaluation of researcher's positionality as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome*" (Berger 2013: 220). In using a phenomenological approach within this study, I am attempting to capture the lived experience of others whilst recognising that there will be an inevitable divergence between articulation of their experience and my personal construction and interpretation of that experience. As a qualified nurse I recognised that I have already experienced the type of transition that I have chosen to explore and the extent to which my own experience has influenced the study must be acknowledged and monitored.

The topic of interest has its origins in my own early experiences as a qualified nurse working with culturally diverse patients; knowing what I 'should' do, wanting to deliver the best quality care I could but not necessarily feeling confident and capable in terms of 'how to do it'. Also working within pre-registration nurse education has served to provide me with further insights (although indirect and limited) regarding the experiences of transition to NQN

status and challenges relating to competence and confidence in caring for people from diverse backgrounds.

This personal and professional history has understandably contributed to my interest in the topic area and has provided some valuable insights when undertaking the study. Immersion in this particular field of study has led to the generation of a number of ideas and assumptions regarding this topic (Berger 2013). As discussed in Section 2.5 there is ambiguity regarding what people understand to mean by the concept of cultural competence. Assuming a constructionist viewpoint, CCPB is understood to have been created by means of the ways in which people (individuals and groups) have actively engaged in creating and transferring this concept as part of the construction of their (social) reality.

This assumption was informed by my own knowledge and understanding of cultural competence and influenced by my experiences as a nurse, researcher and academic working with people from diverse backgrounds. Equally, my own background, values, beliefs, life situation and personal characteristics are part of my cultural identity and this has shaped my perspective on CCPB (see Section 1.3).

I cannot ‘not know what I know’. In addition, this perspective has also been influenced by my understanding of the current literature in the field and the main theoretical framework within which this study positions cultural competence (see Section 4.5.2). My own intuitions or hunches about this

particular topic (Marshall and Rossman 2011) has the potential to frame the study within my 'own particular prism of perception' (Rapport 2004). These initial assumptions regarding cultural competence have potential impacts upon how the study was approached, how data was collected and analysed and ultimately on interpretation of the findings. This is discussed further in Section 7.6.

Becoming aware of these assumptions and identifying mechanisms that prevent these from dominating the research and preventing new and unique perspectives to emerge, can pose a challenge (Jootun et al. 2009, Gray 2009). A transparent approach to data collection, interpretation and analysis within which the researcher's personal assumptions are acknowledged and articulated i.e. 'empathic neutrality' (Ormston et al. 2014) informs this qualitative enquiry in order to meet this challenge. This transparency thus represents an intentional act on the part of the researcher (Berger 2013), contributing to the trustworthiness of the study and facilitating critical understanding. Whilst the extent to which reflexivity is embedded in study methods may vary, a fundamental starting point is an exploration of the researchers' own values, beliefs and presumptions (personal reflexivity).

Self-reflection was an important tool in this study and the process used was that of "*detachment, internal dialogue and constant scrutiny of 'what I know and how I know it'*" (Jootun et al. 2009: 42). Therefore, this qualitative study started with myself (Hill 2006) recognising that this was significant to

understanding and framing both how the research was to be conducted and how the findings were interpreted. My previous experiences and understanding of the topic has provided me with a shared professional language, code of professional conduct and understanding of the healthcare culture in the UK and this may not be available to other (non-nursing) researchers. The nurse-in-transition embarking on a journey from student to autonomous practitioner has resonance with my own experiences. However it was important to acknowledge that this may not be the same for the NQNs in this study. Indeed models of nurse-in-transition have recognised that there is variation in transition experiences (Phillips et al. 2013; Adams and Gillman 2017). My previous knowledge and preconceptions of the topic will evidently influence and impact upon my expectations and interpretations of participant accounts. Personal memories of situations and feelings may lead to prioritising perspectives that are consistent and correspond with my own rather than those that challenge or diverge from this worldview (Berger 2013).

Being attentive or mindful of this potential effect is a mechanism to safeguard against imposing my own personal narrative upon the narrative of the participants (Drake 2010). The mentors, supervisors and role models who supported me in my first post-qualifying post in addition to the culture and ethos of the healthcare setting influenced my own professional identify as nurse and my perceptions of nursing practice. However, as I commenced employment in clinical practice in 1987, educational preparation and the organisational context had substantively changed within the health service in

the UK. The education and practice experiences of contemporary nurses are likely to be significantly different to my own.

The shared professional background and identity as ‘nurse’ required negotiation and navigation of a position that was simultaneously ‘one of us’ (as a qualified nurse) and not ‘one of us’ (as an independent researcher) (Grey 2009). Sensitivity to researcher positionality can mitigate against the challenges of role conflict and the risk of boundary blurring during the research (Bergen 2013). Inevitably my desire to establish trust and rapport with the study participants (I am one of you), impacts upon, and is at variance with, my desire to be perceived in the role as independent researcher. As researcher my role was to listen, prompt and elicit the personal narrative of the participant. However, previous experience of undertaking interviews with nurses has provided me with some understanding of the tendency to gravitate into the perhaps more comfortable role and identity of nurse (I am one of you).

As the researcher is the main data collection tool, engagement with participants via research constitutes a mutual generation of knowledge (Yeo et al. 2014), effectively co-creating a new understanding of CCPB. Personal reflexivity facilitates exploration of values, beliefs and presumptions regarding the topic under investigation, incorporating prior experiences and personal memories (Johnston et al. 2016). This can however lead to assumptions being made in relation to participants’ gender, ethnicity, age, background or any other personal characteristic and their accounts of practice.

Formal approaches to acknowledging and articulating personal assumptions in a structured way can facilitate reflexivity. In this study a journal (both audio and written) was used to reflect upon and record preconceptions prior to data collection and throughout the study. In addition, field notes were made during data collection and when conducting the interviews and post interview reflections were recorded. As recommended by Berger (2013) this approach allowed for insight into two levels of interpretation; what I thought participants may mean (i.e. comments on what they had actually said) as well as what I thought and felt about what they said (i.e. how their views related to my experience, assumptions and preconceptions).

The field notes and journal reflections were also re-examined and used as a reference point throughout data collection and analysis to assess whether my prior assumptions were manifest in the questions or prompts used when interviewing, or in my interpretations of their accounts. Using such an approach was informed by and consistent with the phenomenological interpretative tradition as well as symbolic interactionism; the methodology chosen for the study.

Throughout the study and during the writing up period, I was mindful of my own involvement with the participants' experience. Through a continuous process of reflection, self-examination and critical review I attempted to understand how my own background and experiences had an impact on the different stages of the research process. This reflective process was fundamental to the study and in doing so I was attempting to adhere to the

phenomenological interpretative tradition. Recording my own assumptions or personal prejudices and considering how they directed and influenced my approach could not be described as an attempt to bracket or set aside my assumptions (as in Husserlian phenomenology) but more pragmatically described as an approach to being alert to this possibility.

In this study, my understanding of self-reflection is more akin to the concept of *Bildung* (openness to meaning) as explained by Gadamer (1989). Being aware of self and attempting to be open to what constitutes 'other' in this context was seen as especially relevant to this study as it is also an idea fundamental to understanding diversity and cultural difference. Being open, receptive and non-judgemental about the participants (and about myself) enabled me to listen more fully to the participant experience and resist the temptation to impose my own story (self) upon that of the participants (other). Acknowledging the centrality and significance of self in this study was not without challenge as this was a skill that required practice as well as effort.

It was equally important that I recognised the value and usefulness of my own contribution to this endeavour. Having been involved in previous research studies I had some experience of what this might entail although not at doctoral level. Whilst I considered these skills and experience would be of utility regarding some aspects of the study, this previous experience involved studies using predominantly quantitative methodologies. This had and did influence my perspective when undertaking the research and moving from this background to undertaking a study using a phenomenological approach

required a considerable shift in my own personal understanding and perspective on research and knowledge. One of the advantages of undertaking the pilot study was that it provided an ideal opportunity to develop and hone personal reflection skills and consider this philosophical repositioning.

4.5 Methodology and theoretical framework

Methodology refers to more than just the methods used to undertake a study. Specific reference should be made to the concepts and theories that underpinned the method chosen, methodology then can be described as "*a bridge between theory (ideas) and method (doing), offering consistency and coherence throughout the entire research process*" (Kramer-Kile, 2012: 27). Whilst quantitative and qualitative methodologies are often portrayed as opposing and polarised positions, this distinction may arguably be overstated (Benzies and Allen 2001). Alignment of methodology exclusively with particular paradigms may not necessarily be useful or suitable (Krauss 2005) and within the field of nursing research the need to identify research priorities that can improve the patient experience often drives the research agenda rather than a focus on underpinning philosophy (Smith et al. 2011).

Whilst the rise in mixed-methods could be seen as testimony to the recognition of the contribution and value of each of these methods to health research, Sale et al. (2002) urge caution in this 'blurring of boundaries' as methods are representative of, and derived from different philosophical

starting points in terms of ontology and epistemology. The methodology chosen must also be congruent with, and informed by, the philosophical paradigm and the phenomena of interest. Therefore, a methodology was chosen that was underpinned by an ontological assumption that was acceptant of multiple realities and perspectives and recognised the interaction between researcher and the participants in the study. The methodological framework chosen provided "*a lens by which the researcher can extract meaning, understand processes and, in turn, generate theory itself*" (Kramer-Kile, 2012: 29). The epistemological perspective in this study was derived from constructionism and the resultant methodology was an interpretative qualitative enquiry informed by Symbolic Interactionism (SI) (Crotty 2003).

An interpretative approach was deemed appropriate for this study, given that the purpose was to explore nurses' perceptions of a particular phenomenon. In addition, the social, cultural and environmental context of both participant and researcher was relevant to understanding the phenomenon under investigation (Earle 2010; Pringle et al. 2011). Interpretative qualitative enquiry had its roots in the interpretative tradition and was approached with specific reference to the central principles of symbolic interactionism. Symbolic interactionism and interpretative methodologies share common ontological and epistemological assumptions (Matua and Van Der Wal 2015). The interpretative researcher accesses participant experiences and rather than explaining this in causal terms seeks to explore and explain phenomena via an understanding of the meaning people ascribe to their experiences. The

value of this approach to the study was that it focused on peoples' subjective and inter-subjective experiences and recognised that the meanings they ascribed were influenced by culture and context as they interacted and engaged with the world (Benzies and Allen 2001; Charon 2010).

This approach thus facilitated an understanding of the nurse's experiences in terms of the social context in which their interactions with patients took place. In this study, nurses engaged and interacted with patients within the specific context of healthcare practice and their perceptions of CCPB and its meaning were derived from and explained within this context. Interpretative methodologies (as opposed to descriptive approaches) provide a focus for shared meaning-making between participant and researcher. The phenomenological labels that could be used to describe this are numerous. For example 'fusion of horizons (Gadamer 1989) and co-constitutionality (Flood 2012). The label chosen represents a researchers' connection to a particular philosophical tradition, epistemological viewpoint or preferred methodology (Earle 2010). In this study, the creation of knowledge of the phenomena (CCPB) was positioned with reference to the central premise of symbolic interactionism, that is, the object and subject are interrelated and co-dependent in the development of shared meaning.

4.5.1 Symbolic interactionism

Symbolic interactionism has its roots in pragmatism (Charles Pearce 1839-1914) and George Herbert Mead's (1863-1931) idea of the distinction between

the ‘I’ (the spontaneous non-reflective self) and the ‘Me’ (the reflective self) which provided the foundation for the perspective known as symbolic interactionism. Symbolic interactionism is based on the premise that “*to understand human action, we must focus on social interaction, human thinking, definition of the situation, the present, and the active nature of the human being*” (Charon 2010: 29). Mead argued that an individual becomes self-conscious through an internalised conversation of the ‘Me’ constantly monitoring the ‘I’ and the self is conceived as a social entity rather than a psychological one. Herbert Blumer (1900-1987) a sociologist, developed the work of Mead and first used the term symbolic interactionism. Blumer (1969) argued that there are three central premises;

1. Human beings act towards things on the basis of the meanings such things have for them
2. The meaning of such things is derived from, or arises out of, the social interaction that one has with one’s fellows
3. These meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he/she encounters

In Blumer‘s (1969) view, meaning arises through a two stage process of interpretation in which the person first communicates with him/herself (an internal process) regarding the ‘object’ with which they are interacting. Then, the person reflects on and transforms the meaning of the ‘object’ in light of the current situation and environment and acts accordingly. Especially important within an interpretative interactionist approach is the notion of

symbols; the abstract meanings people ascribe to objects, people and behaviours.

Essentially anything can be a symbol within this perspective, however for the purposes of this study and informed by Charon (2010), words, objects, and acts will form the three main symbolic categories. Words as symbols are especially important (Benzies and Allen 2001), they allow people to communicate ideas to each other and with themselves, thus objects and acts are made into symbols by the words people use to describe them (Charon 2010). Uncovering the meaning that CCPB has for NQNs thus requires specific attention to and analysis of the words they use to describe their experiences. Objects may have different meanings for different people but it is possible for commonalities of meaning to emerge and this is especially the case for the words used to describe objects within specific context and situations such as nursing practice. Words are used to describe our actions, the words are important as well as the interpretations of what those actions mean for individuals within a given situation. Therefore, it is important to consider what people think, perceive and believe but also consider how they act, and specifically what words they use to describe their actions. Therefore the words that nurses use are relevant to understanding the beliefs and attitudes that underpin these 'utterances' (Charon 2010). Symbolic interactionism provides the necessary insights into, and connectivity with, actions and behaviours (CCPB) (Oliver 2011). These actions are understood in terms of "*definition, interpretation and meaning*" (Benzies and Allen 2001: 542). Within symbolic interactionism, people are considered active in relation

to their environment rather than passive (Charon 2010) and it is through interaction that people interpret the actions and meaning of other individuals' behaviours. Rather than the measurement of observable behaviour as in behavioural psychology, the focus remains on the internalised conversation that requires the person to put themselves in the place of another and reflect upon and consider how someone else feels, thinks or behaves (Charon 2010). Conceptually, this aligns well with the requirement for self-reflective practice in nursing and the core competencies required of NQNs (Bulman et al. 2012; NMC 2015).

Symbolic interactionism was derived from the tradition of phenomenological philosophy and its essential constituents have similarities with other methodological approaches within this worldview such as those espoused by Husserl, Heidegger, Gadamer, or Merleau-Ponty (generally characterised as the 'phenomenological methods'). Symbolic interactionism thus emerged as one particular derivative of phenomenology as philosophy, however it was not characterised as a phenomenological method. Informed by theoretical traditions in social psychology, sociology and anthropology, I would argue that the approach is essentially constructionist, phenomenological and interpretative (Bryne and Hayman 1997; Earle 2010; Matua and Van Der Wal 2015) and this is consistent with other nurse researchers (Oliver 2011). Symbolic interactionism is both phenomenology as philosophy and phenomenology as methodology and is considered of particular relevance to the field of nursing research as it is a useful methodological approach to generate new perspectives on nursing practice (Bryne and Hayman 1997:

Benzies and Allen 2001; Balls 2009; Earle 2010; Pringle et al. 2011; Matua and Van Der Wal 2015).

Symbolic interactionism provides a useful methodological approach that can be useful in understanding nursing practice and particularly nurses' interactions with patients. Its focus is on understanding human interaction and behaviour and specifically "*how individuals interpret objects and other people in their lives and how this process of interpretation leads to behaviour in specific situations* (Benzies and Allen 2001: 544). The relevance of symbolic interactionism to understanding CCPB is essentially located within Blumer's (1969) premise that "*The meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows*". Thus it is located in and contextualised by the nurse-patient interaction situated within a healthcare setting. Thus its application to understanding contemporary nursing practice and behaviour is particularly pertinent at a time when healthcare organisational culture and context is considered relevant to care delivery (Francis 2013; West et al 2017).

The original symbolic interactionism approach has however come under considerable criticism for not fully articulating a resultant methodology (Benzies and Allen 2001), although arguably the same challenge could be levelled at the original work of Husserl, and Heidegger. The initial failure of early symbolic interactionists to operationalise key constructs and

assumptions related to social structures and its cognitive and emotional processes was well founded, however subsequent work has sought to address these challenges (Fine 1993; Charon 2010). Whilst symbolic interactionism can be considered a useful theoretical perspective to understanding social interaction, it must be acknowledged that this directs the study to focus on the social rather than psychological or biological aspects of nursing (Benzies and Allen 2001). Whilst this challenge is acknowledged, the use of symbolic interactionism to explore this topic is supported by both the topic chosen and the methodological underpinning for this study. Interpretative, constructionist approaches share common assumptions regarding epistemology and ontology with symbolic interactionism and are consequently compatible (Oliver 2011).

CCPB as described in the seminal work by Campinha-Bacote (2002) involves the nurse applying their learnt awareness, sensitivity and knowledge to the interaction or encounter with patient. This model emphasises the relevance of this interaction and engagement with patients from diverse backgrounds. Secondly, symbolic interactionism is also concerned with how interaction with others contributes to the commonly created beliefs, attitudes and behaviours shared between individuals and within groups. As Bryne and Heyman (1997) have argued in their study using symbolic interactionism, the professional training of the nurse and socialisation experiences within the workplace are relevant to understanding the nurse-patient interaction. The importance of this to understanding CCPB has been discussed in Section 2.6. The rationale

for using a framework informed by symbolic interactionism is supported by the premise that interaction with others (patients and colleagues) "*may contribute to the individual learnings sets of beliefs, attitudes and behaviours held in common*" (Benzies and Allen 2001: 95).

Whilst other methodologies within the phenomenological tradition were considered, they did not necessarily provide the unique connection between nurses, nursing practice and social and organisational context that symbolic interactionism provided. One of the advantages of symbolic interactionism is that it is not overtly prescriptive and, or absolutely aligned with a defined method. The approach offers flexibility and is equally applicable to qualitative and quantitative methods (Benzies and Allen 2001). Whilst there are a number of different methodologies suitable for a study that seeks to provide in-depth description of peoples' perceptions, symbolic interactionism provides a framework that was considered most fit for purpose. Importantly, it was aligned with the phenomenological tradition and was consistent with the framework of the Developmental Model of Intercultural Sensitivity (Bennett, 1986; 1993) used to provide a theoretical framework for the study (Kramer-Kile 2012) (see Section 4.5.2). Importantly it does not seek to understand the nurse in isolation but as individual with their own background and identity who interacts with patients and colleagues within a specific organisational context of care.

An ethnographic methodology was also rejected although it would have provided a means to enable direct observation of the interaction between a newly qualified nurse and patient. The purpose of the study was however to describe and explore a particular phenomenon from the perspective of participants and the meanings ascribed to those experiences. Observation has an obvious impact on the person being observed and apprehension of those being observed (practitioner or patient) may limit or prevent natural behaviour. This may have resulted in participants modelling behaviour they think the researcher wanted to see thus behaving in a way that maintains the relationship rather than challenging it. Multiple and prolonged periods of observation are necessary to undertake participant observation in a rigorous way and is thus time and resource intensive and not necessarily feasible within a time limited study. The level of observation needed to conduct an ethnographic study may not be possible in the current climate in the NHS where organisations are already experiencing increased scrutiny from an array of professional and regulatory bodies.

Other traditional phenomenological methodologies were however drawn upon to ensure add rigour to the approach. As the researcher was considered participatory in the generation of meaning and was inseparable from the data, preconceptions were acknowledged (McCance and Mcilfatrick, 2008) via reflection and recording of assumptions. This could not be considered as true “bracketing‟ (as in Husserlian descriptive phenomenology). Setting aside influences and preconceptions that remain unconscious, inaccessible or are not known is fraught with difficulty

(Johnston et al. 2016). It could be argued that identifying and including preconceptions within the data (forestructure) as part of an interpretative process is also equally problematic. However, the researcher's own assumptions, motivations, experiences and prior knowledge from the field were made visible via reflective mechanisms to inform data collection and analysis and as part of the qualitative enquiry audit trail. This allowed the researcher to examine the findings and explore the differing contributions made by researcher and researched and remain alert to the impact of assumptions and preconceptions on data collection and analysis.

A qualitative approach thus allowed for an exploratory, interpretative account that served a contextual and explanatory function (Richie and Ormston 2014). Where a study seeks to investigate subject areas that are deeply personal, related to values or beliefs or require insight into aspects of self, a qualitative approach allows for subtle and sensitive probing to get below the surface of a stylised or immediate response. The complexity of the phenomena under investigation requires reflection by participants on both the nature of CCPB and their own beliefs and views regarding diversity. The objectives in combination with the nature of the subject matter necessarily point to the need for a qualitative-only approach as the current knowledge base precluded a study using quantitative approaches until further detail is known of the phenomena (Richie and Ormston 2014). A qualitative (only) design was therefore used as this would enable an exploration of NQNs perceptions informed by the personal experience of the participants in their own words (Smith et al. 2011). The symbolic interactionism 'lens' was used

to aid understanding and to examine and explore changing perceptions of CCPB with due consideration of the phenomenon of interest, the level and type of research questions and the current evidence base.

4.5.2 The Developmental Model of Intercultural Sensitivity (DMIS)

In addition, and used in conjunction with this methodological framework, a theoretical perspective consistent with that of symbolic interactionism was used, that of the DMIS, a theoretical model developed by Bennett (1986; 1993; 2004) and sometimes referred to as 'The Bennett scale'. This six stage framework describes the way people react to and understand cultural differences (Cushner et al. 2012). The important contribution of the DMIS to this study is that it provided a framework with which to explore the way that individuals understood and responded to cultural difference. Based on an underlying assumption that each stage was characterised by a particular worldview, this model presumes personal growth and development along the continuum driven by interaction with different cultural groups (Perry and Southwell 2011). Each position along the continuum was seen as representing the way that individuals assimilated and responded to increasingly complex cultural information and perceptions of others. Thus the cultural encounter, like in models of cultural competence is central. In addition, what individuals understand to mean as 'other' arises out of the interaction and views are modified via an interpretative process (as in symbolic interactionism).

The DMIS is in essence phenomenological, representing particular worldviews within each of the stages. However, development and change of worldviews via adaptation can occur, and the resultant behaviours are a consequence of increasing intercultural sensitivity. According to Hammer et al. (2003) the DMIS provides an explanation of how people 'construe' cultural differences as they interact and engage with others. The first three stages along the continuum are described as 'ethno-centric' with movement along the scale to a more 'ethno-relative' point of view. It is not assumed within the framework that progression through the states is always unidirectional or permanent and consequently regression or stagnation can occur. The stages in the DMIS Model are described below (Bennett 1986; 1993; 2004);

Stages 1-3 Ethnocentric

1. **Denial of Difference** – in this stage individuals consider their own culture as the 'real' one. They are essentially unaware of other cultures, or if noticed they are understood in simplistic terms and they are not interested in cultures beyond their own.
2. **Defense against Difference** – a person's own culture is seen as superior, or in Bennett's words 'the most evolved'. This stage is characterised by the people seeing their own culture as the norm, and can feel threatened by 'other-ness'.
3. **Minimization of Difference** – People are more aware of similarities between people from different cultural groups. Although people consider themselves accepting and tolerant of others, this is often superficial and fails to acknowledge their own privilege.

Stages 4-6 Ethnorelative

1. **Acceptance of Difference** – the individual becomes more accepting of different worldviews, recognising that their perspective represents one of many. They may not agree with (or like) some aspects of other cultures but are more appreciative and respectful of them.
2. **Adaptation to Difference** - Individuals in this stage are consciously understanding cultural difference (cognitive adaptation) as well as being able to engage in appropriate cultural behaviour (behavioural adaptation).
3. **Integration of Difference** – In this final stage, acceptance of difference is integral to the worldview of the individual. They are able to think and behave flexibility and move in and out of, and between different cultural viewpoints.

So, within this model proposed by Bennett (1986; 1993) individual responses to cultural difference could be characterised as a particular worldview. By determining which worldview an individual was located in, further development along the continuum could be facilitated by education. Personal change and progression occurs as individuals engage with cultural differences, assimilate and adapt to those experiences and move along the continuum. Bennett (1986; 1993) provided further detail to the framework describing the movement between the worldviews as; from denial to defense; from defense to minimisation; minimisation to acceptance; acceptance to

adaptation; and finally from adaptation to integration. Movement between the stages necessarily involved engaging with cultural difference. As movement between the stages occurs, the individual increasingly comes to understand and be conversant with different cultural worldviews.

The value of Bennett's work is that it represents a complex model that incorporates affective, cognitive and behavioural constructs as well as responses to cultural differences. The model has synergy with other models and theories characterised by shifts from simple to complex understanding, rigid to flexible thinking all of which are illustrative of the use of multiple frameworks or schemas during problem solving (e.g. cognitive flexibility, schema development, cognitive dissonance, divergent thinking) (Endicott et al. 2003).

Although the DMIS has its critics (Hammer 2011), the detail of the model and the complexity it represents provides a comprehensive theoretical framework within which to frame the study. The importance and value of this model informed the development of a specific measurement tool the Intercultural Development Inventory (IDI). This inventory has been subjected to vigorous testing via research (Paige et al. 2003, Hammer et al. 2003, Bennett and Wiseman 2003, Hammer 2011). Although the IDI was derived from the DMIS model it represents an adaptation as it was primarily concerned with

measuring development along the continuum to the point of adaptation rather than as a measure of identity development (Hammer 2011; 2012).

The IDI has undergone several permutations to refine its constructs, the testing of which have validated and confirmed the basic dimensions and orientations as originally outlined by Bennett (1986; 1993). Although, Hammer et al. (2003) concluded that the data did not fit well with a two dimensional model (ethnocentrism / ethnorelativism) and later proposed a five dimension model (the Intercultural Development Inventory (IDI) (Hammer 2011; 2012). Testing of inter-scale correlations for the IDI did not present a factor structure that was an exact fit with that of the DMIS. It did however appear consistent with the DMIS model to a considerable degree and importantly supported the notion that the DMIS was a developmental continuum (Paige et al. 2003). Subsequently, Hammer (Hammer et al. 2003: Hammer 2011; 2012) proposed an alternative model – The Intercultural Development Continuum (IDC) which was a revision of some aspects of the DMIS and the IDI became a tool to measure the IDC. Bennett (2009) has challenged Hammer's analytic approach and interpretation of the data in the development of the IDI. Although this was countermanded by Hammer (2011), the evidence supporting the argument referred primarily to the reported reliability and validity of a number of studies conducted by Hammer and his team.

A choice was therefore made to use the DMIS as a theoretical framework as originally proposed, rather than the IDC which can be considered "*a revised theoretic framework, which the IDI in turn measures*" (Hammer 2012: 118). The DMIS was considered to be particularly suitable to frame understanding of NQNs and CCPB. As the NQN undergoes the 'journey' from novice to autonomous practitioner, it was hypothesised that development mediated by cultural 'encounters' and experiences of cultural diversity within the healthcare environment would provide opportunities for further understanding and integration of information regarding other cultures. Interaction with people (patients) from diverse background routinely occurs in the clinical environment, and this is provides the opportunity for NQNs to engage with cultural difference and alter their world views as they move along the continuum. Although as Bennett (2004) argued this might not necessarily occur.

Whilst each individual practitioner may start at a different point on the DMIS continuum, it was considered feasible that continued and repeated exposure would facilitate and promote development along the continuum. Referring back to Blumer's (1969) three central premises, it can be argued that nurses act towards patients on the basis of the meaning that 'patient' has for them. This meaning is derived from and arises as a consequence of social interaction within the context of healthcare practice and is influenced by professional education, socialisation, context, individual characteristics and background (Byrne and Heyman 1997). Thus, when a nurse interacts with a patient this meaning is continually modified via an interpretative process used

by the nurse when dealing with the things (patients or objects) that they encounter (Blumer 1969). As NQNs enter the world of work and 'start the journey', this construction is informed by, influenced and mediated by external, environmental, professional and organisational reference points as they become acclimatised and socialised within this new role. There is a necessary interactivity between the culture of the individual and that of the patient and organisation. This dynamic interaction resonates with the constructionist viewpoint and also that of symbolic interactionism (Charon 2010).

When caring for and interacting with patients, the nurse engages in an internalised conversation; the 'Me' (the reflective self) monitors and mediates the 'I' (the spontaneous non-reflective self) with specific reference to the meaning of the 'object' (or patient) with whom they are interacting. The NQN through a continued process of interaction, reflection and action is capable of the adaptation required to facilitate movement along the DMIS continuum. Thus, the NQNs in this study were conceptualised as undergoing two simultaneous journeys; the first is from novice to autonomous practitioner and the second is movement along the developmental continuum theorised in the DMIS. The relevance of interaction with others can be seen clearly in Bennett's model, in models of cultural competence and is a central premise of symbolic interactionism.

4.6 Study design

A qualitative longitudinal study using an interpretative enquiry framework informed by symbolic interactionism was undertaken. The justification for the approach taken was provided in the previous sections, however the need for the study to encompass a longitudinal approach requires further explanation. A longitudinal approach is characterised by data being collected on each variable at two or three time points (Watson 2008), the same subjects are involved from one time point to the next, and analysis involves some comparisons between time points (Bolger et al. 2013).

Previous studies examining the transition of NQNs (Dearmun, 2000; Evans, 2001; Duchscher, 2008; Andersson and Edberg, 2010, Lima at al. 2016) indicated that transition occurs over a period of time (see section 2.6). In order to capture change in perceptions, repeat data collection points were methodologically necessary and appropriate. Single point studies exploring transition suffer from methodological flaws including retrospective bias (Alaszewski 2006; Lewis and McNaughton Nicholls 2014) and by collecting data over a period of time, changes in perceptions can be captured rather than relying solely on recalled experiences. When micro (individual) level change is being explored, qualitative longitudinal approaches facilitate the capture of this transitional experience, at the starting point, during, and at the end (Bolger et al. 2013; Lewis and McNaughton-Nicholls 2014). Consequently, the transition of NQNs was conceptualised as a ‘journey’ with

a clearly defined starting point (qualification) and distinct phases informed by previous research in this field (as shown in Section 5.4).

4.6.1 Study sample

A volunteer purposive (criterion-based) sample was chosen for the study. A purposive sample was selected because they had specific characteristics or features that were relevant to the focus and aim of the study (Ritchie et al. 2014). Members of the sample were chosen because they satisfied a specific purpose and were homogenous, i.e. they were from the same group or sub-culture as they were all NQNs. As Ritchie et al. (2014) have argued "*qualitative sampling requires a different logic to quantitative inquiry*" (2014: 113), and the sample was not intended to be representative, nor the findings generalisable.

The sample consisted of NQNs as defined by the following characteristics and inclusion criteria;

1. Had successfully completed an approved programme of pre-registration nurse education within the UK with an NMC approved provider of education.
2. Were registered with the NMC on the relevant part of the register as a qualified nurse (e.g. RN1: Adult nurse, level 1, RNMH: Mental health nurse, level 1, RNLD: Learning disabilities nurse, level 1 or RNC: Children's nurse, level 1)

3. Were commencing or intending to commence employment in the UK health sector as a qualified nurse (either in the NHS, private, or voluntary or third sector services)

Participants were excluded from the study if;

- They had already commenced employment and been employed for longer than three months (i.e. had already passed the first transition point for the study)
- Had successfully completed an approved programme of pre-registration nurse education outside of the UK and had recently commenced work in the UK (as the experiences of IEN were likely to be substantively different to UK educated NQNs)
- Were commencing or intending to commence employment in the UK as a health professional but not a nurse

Determining the appropriate sample size for a qualitative study requires due consideration (Ritchie et al. 2014) as failure to recruit sufficient numbers into a study can impact upon data quality (Fusch and Ness 2015). However, as argued by Mason (2010), sufficient data must be generated in order to reach data saturation that is, no new themes or concepts are emerging during analysis. In this study, 42 pieces of rich qualitative data were obtained from 14 participants, increasing the likelihood of saturation. It is feasible that additional numbers of participants would have allowed other themes to emerge (Ritchie et al. 2014). However, the sample size in this study and the amount of data generated is consistent with previous qualitative studies of

transition (Evans 2001; Delaney 2003; Duchscher 2008; Andersson and Edberg 2010).

However, data saturation is an inexact science and the extent to which saturation is reached must be demonstrated through a systematic and rigorous approach to analysis (Fusch and Ness 2015). In addition, an assessment must be made in relation to realistic management of the amount of data within the timeframe allocated (Shih 1998; Smith et al., 2011), and whether the study aims and objectives have been met (Mason 2010).

4.7 Study methods

The study used two key approaches from within the same methodological tradition; participant directed reflections, complimented by, and in conjunction with semi-structured interviews. The development of the directed reflections and interview topic guide are discussed in more detail in section 5.2.1.

4.7.1 Participant directed reflections

In this study, participants were directed to reflect upon their current practice as a valuable and effective way of capturing data which provided 'in the moment' accounts of practice (Alaszewski 2006; Snowden 2015; Bartlett and Milligan 2015). Participants completed the directed reflection in the knowledge that this would be read and interpreted by the researcher (Clayton and Thorne 2000) and according to Snowden (2015) this approach is

advocated when undertaking research "*of a sensitive nature that aims to track behaviour and differences between or in participants over a period of time*" (2015: 37).

Informed by the use of diary methods in research (Bolger et al. 2003; Bartlett and Milligan 2015), the directed reflection was completed at two distinct points in time to minimise participant burden and enhance compliance rates (Thomas 2015). Compliance can be especially problematic when completion is continuous (Bartlett and Milligan 2015) but this can be minimised if an intermittent completion approach is chosen. Therefore, as directed by Bolger et al. 2003, a fixed schedule' or 'time modelled' approach was chosen underpinned by the concept of the transition journey as "*such designs are best implemented at times when change is likely to occur*" (Bolger et al. 2003: 586). Completion of the directed reflections was consequently scheduled to be undertaken at specific points in time relevant to the transition journey of NQNs (see section 5.4).

Longitudinal studies that require multiple point data collection are prone to participant attrition (Jacelon and Imperio 2005) and fixed interval data collection minimises demands upon participants and reduces the risk of incomplete data being produced (Watson 2008). Therefore, completion of the diary sheet was scheduled for the end of the induction and orientation experience (2-3 months) and again at the end of period of supervised practice (5-6 months).

In terms of ensuring participant engagement with the diary, regular contact and prompts can also encourage completion (Bartlett and Milligan 2015) and information contained within diaries can also be checked with the participants themselves (member checking) using summary sheets, post diary interviews or interpretation and meaning validated by an external panel of 'experts (Jacelon and Imperio, 2005). In this study, the post transition stage interview provided an opportunity for the researcher to explore with participants the directed reflections and clarify understanding and address any misconceptions.

The advantages of using directed reflections completed in 'real-time' was that it reduced the likelihood of retrospection bias as the amount of time between the event and the account was minimised (Alaszewski 2006; Lewis and McNaughton Nicholls 2014). In addition, directed reflections are a common feature of both pre and post-registration nursing practice in the UK and familiar to the participants (Bulman et al. 2012). They are able to produce data of considerable depth and quality (Snowden 2015) and encourage disclosure, honesty and reflection (Torsvik and Hedlund 2008). Using the diary approach is also more effective when combined with interviews (Bartlett and Milligan 2015) as was the case in this study. In addition, interviews when combined with diary methods can replace participant observation (Jacelon and Imperio 2005). The directed reflections provided the NQNs with a means by which to record their reflections on practice and although directed to focus on a particular topic, participants were able to choose the scenario and provide descriptions of this in words of their choice. Consistent with the

philosophical stance of the study, it was deemed important to ensure that participants were provided with greater control over how their experiences were represented (Woll 2013).

This method is not however without its methodological challenges and disadvantages. When using directed (solicited) reflections, the content is to a large extent determined and controlled by the researcher not by the participant (O'Brien and Clark 2012; Thomas 2015). This raises a key concern relating to researcher positionality and power within the relationship and research context (Bartlett and Milligan 2015). However, a semi-structured approach may legitimately be used to influence and direct participant entries, and maintain balance between the agenda of the researcher and that of the participants (Thomas 2015). Bolger et al. (2003) have argued that writing about a phenomenon alters participant perceptions. However, as this study did not require continuous or repeated writing the impact of this would have been minimised.

The extent to which structure is imposed on the directed reflection depends upon the purpose of the research and the methodology used for the study. A template was created based on commonly used examples in pre-registration nurse education to enable consistency in data capture both within and across the study sample. Feedback was sought from a group of patients and carers who were part of an advisory group located within the academic institution in which the researcher was located. The template was structured so that

participants were directed to provide specific information that described their thoughts, views, actions and behaviour. The template also provided a section specifically for unstructured expression as recommended by O'Brien and Clark (2012), Thomas (2015), and Bartlett and Milligan (2015).

Participants can tend to provide an account of their experiences which they think 'puts them in a good light' or write what they think the researcher wants to hear. This is a common challenge in research that relies upon participant self-reporting of experiences. However, follow up interviews provided an opportunity for further exploration of the participant accounts and more unstructured expression (Clayton and Thorne, 2000). In addition, whilst this may well be a limitation of directed reflections, it is countered by the argument in favour of participant control over content (Woll 2013). Completing directed reflections may lack the subtleties of an interview in relation to non-verbal nuances, it does however provide an authentic reflective account of participants' practice, their views and experiences. They may result in less spontaneous accounts or self-edited responses, but the interviews supplemented and complimented this approach and enabled the researcher with an opportunity to solicit expansion of particular points (Bartlett and Milligan 2015).

4.7.2 Interviews

The purpose of qualitative interviews is to elicit the participants' perspectives in their own words regarding the phenomenon under investigation (Jack 2008). Interviews are a common method used in nursing research, although its over-use has been criticised (Silverman 2011). The qualitative interview is used to gather in-depth, rich descriptions from the interviewee regarding their experiences (Jackson et al. 2008). The role of the researcher in the interview, as either accessing participants' knowledge or co-creating new knowledge via the interview process is dependent upon epistemological view point (Yeo et al. 2014). Within a constructionist methodology, interviews represent an interaction between the researcher and interviewee to create and generate meaning (Silverman 2011). Within this study, an assumption was made that the participants' individualistic and subjective constructions of CCPB could be communicated and shared during the interview, and that the interviewer was the research instrument.

Using a focused qualitative interview format allows the researcher to discuss the key topic of investigation whilst still enabling sufficient flexibility to change the order of questions or to follow up particular experiences (Yeo 2014). Questions may however elicit unanticipated responses (Smith 2008) and it was important that prompts or probes were used at suitable points to encourage elaboration of responses that were relevant and, or guide participants back to the focus of the question. Whilst a number of methods of qualitative data collection could be used to elicit participant responses such

as focus and, or discussion groups it is recognised that such an approach might not be appropriate for this particular study.

Focus groups are considered a useful approach in exploratory research (Redmond and Curtis 2009) and have been previously used in studies of transition and in health and social care research more widely (Orvik et al. 2013). Both focus groups and interviews are approaches from within the phenomenological tradition that seek to elicit personal narratives (Finch et al. 2014). In the former, the interaction between group members forms an essential element of the approach and are particularly suitable for studies that aim to explore different perspectives and a shared understanding of a given topic (Traynor 2015). Individual interviews allow the researcher to 'get below the surface' (Yeo et al. 2014: 184) and access individual personal narratives (Lewis and McNaughton-Nicholls 2014).

The decision as to whether to use focus groups or not should ultimately be informed by the study purpose (Redmond and Curtis 2009). Directed reflection (diary method) can be combined with other methods including focus groups (Bartlett and Milligan 2015). However, focus groups are not always suitable when individual perceptions are being explored as personal accounts may be obscured by dominant individuals within the group (Finch et al. 2014). In this study, the directed reflections completed by participants during months 2-3 and 5-6 formed the basis for further discussion and participants might be reluctant to discuss their personal reflections within a group setting (Redmond and Curtis 2009).

In addition, whilst a focus group might be feasible when all the participants are in one location, this is likely to prove challenging to arrange when they are geographically dispersed and working in different settings and at different shift times (as in this study). A central location would be necessary requiring the participants to travel and sacrifice personal time in order to participate (Traynor 2015). The cost would also be substantive and whilst not an over-riding consideration, resource implications are a necessary feature of research (Shih 1998). However, methods such as on-line focus and discussion groups are increasingly used specifically to address such challenges and this may well have provided an alternative option (Snelson 2016). The purpose of the study with its focus on individual perceptions and the personal journey of the NQN informed the decision to select individual interviews rather than focus groups.

The purpose of the semi-structured interview was two-fold (see Appendix 4). Firstly, the interview aimed to explore and understand the participant perceptions and views of their experiences as well as the organisational context in which the experience took place. Follow-up questions and prompts were used throughout as and when appropriate (Jackson et al. 2008) and participants were encouraged to reflect upon and elaborate on their experiences both negative and positive (Smith, 2008). Secondly, the interviews discussed with participants the data they provided in the directed reflections enabling data checking, clarification and elaboration on concepts and researcher interpretation (Yeo et al. 2014).

Telephone interviews offer the advantage of being able to access a geographically diverse population (Harris et al. 2008), are versatile (Novick, 2008) time and resource effective, and can produce data that is comparable to the face to face method (Carr and Worth, 2001; Sturges and Hanrahan, 2004; Harris et al. 2008; Yeo et al. 2014). Importantly they enable the participant to undertake the interview at a time and in a place convenient to them and this is a necessary consideration as the participants were busy professionals often working unsocial hours and located in geographical diverse settings.

Telephone interviews are commonly used in nursing research and practice particularly once contact with participants has been established (Carr and Worth, 2001) and enable data collection without face to face contact. However, the lack of visual clues offered by telephone contact may adversely affect the interview as the researcher is unable to provide encouragement through non-verbal means (nodding, smiling), and this can hinder rapport (Trier-Bieniek 2012). Whilst these disadvantages are noted using an indirect approach may make the participant feel more relaxed or less intimidated by the researcher (Novick, 2008) and can consequently facilitate disclosure of information and the establishment of rapport (Harris et al., 2008). In addition, as the researcher cannot see the interviewee, this approach may also prevent them from making assumptions based on personal presentation or characteristics.

When telephone and face to face interviewing modes are compared there appears little difference in the amount or quality of data generated (Sturges and Hanrahan 2004; Ward et al. 2015). In respect of this study, telephone interviews are considered the least disruptive and intrusive approach for participants and potential disadvantages can be minimised by an assertive approach by the researcher and advance preparation (Harris et al. 2008). The value of conducting interviews at the conclusion of the data collection period was that there was an opportunity for the researcher to discuss with participants the information provided in the directed reflections and explore potential misunderstandings and misconceptions prior to analysis.

4.7.3 Study trustworthiness and credibility

Whilst the terms reliability and rigour are pervasive in the literature of quantitative research, in qualitative research alternative terms and concepts are used. Trustworthiness, credibility, transferability, dependability and confirmability are key issues for qualitative research rather than the positivist constructs of reliability and validity (Creswell and Miller 2000). Key to demonstrating this within an interpretative approach is ensuring that the resultant subjectivity is made explicit and transparent (Creswell 1998; Lincoln and Guba 2000). Creating an audit trail is necessary that documents the flexible, emergent process indicative of qualitative methodologies and makes it possible for another researcher to follow the approach and decision-making strategy within this flexible framework (Lincoln and Guba 2000). Essentially, the credibility of the study (or 'truth value') (Searle 2012) requires a

transparent approach to process and outcome demonstrating that that data has been authentically represented. Specific principles and procedures can be followed to maximise credibility (Rossman and Rallis 1998; Ohman 2005), however methodological explanation and justification throughout a study should be used to demonstrate how adequately the multiple understandings are presented (Bazeley 2013).

This study sought to generate rich, detailed contextual data that would inform a credible interpretation of CCPB as perceived by NQNs. Within a study using a qualitative methodology, there is an assumption that multiple realities exist and credibility is used to refer to the extent to which the researcher has captured these realities. Detailed records were kept throughout the study including communication with participants, audio and written notes created during transcription and analysis to create an audit trail of the study from data collection through to generation of the findings. Intentionally making explicit the researcher's own assumptions, positionality and decision making throughout are important for demonstrating credibility and confirmability (Berger 2013) and in doing so the authenticity of the interpretation can be examined and questioned. Further details on this process are explained and reflected upon in Section 5.5.

The interviews were accurately transcribed within 48 hours and the research supervisor was supplied with a randomly selected transcript to examine in relation to the thematic maps generated as an additional check to the validity

of the analysis (Bazeley 2013). Data analysis was conducted in three distinct stages (the transition points), and at each point these were discussed and checked prior to beginning the next stage. Principles of effective data management were adhered to in order to provide structure to the process and ensure appropriate record keeping (Spencer and Ritchie 2012). Prolonged engagement with the study population using multiple data collection points as was used in this study, rather than in a 'one-off' approach and this can enhance credibility of the findings (Ohman 2005). The interpretations of the directed reflections were also discussed with participants to add further credibility to the study findings and validate my perceptions of their accounts of practice.

Demonstrating whether the study findings can be satisfactorily applied to other settings and populations (transferability) is also important. As argued by Lincoln and Guba (1985), transferability can be challenging without knowing the contexts or settings to which the findings might be applied in the future. However, sufficient descriptive detail of the key study procedures, methods, analysis, sample and findings support the demonstration of transferability (see Chapter five). This is however, distinct from the notion of generalisability which has been dismissed as not relevant and, or applicable to qualitative research (Ohman 2005).

Qualitative research generally uses smaller samples with detailed, in-depth analysis rather than using large-scale population-based studies that seek to demonstrate generalisability of the findings. However, knowledge developed

from studies of human life and interaction within a social context has increased transferability when ‘theory competence’ is demonstrated. That is, the study findings are explained with reference to appropriate methodological theoretical frameworks (see Section 4.5), and alternative explanations for the findings are considered and contextualising factors discussed and explained (see Chapter 7). In this study, it is recognised that the findings were population and context specific, however, they were supported by and consistent with other research in the field of both CCPB and transition.

The credibility of the study is also connected to its rigour and it is important that the study is well designed, coherent, and that the relative merits of the research methods are justified (Bazeley 2013). The relationship of the study design and methods to the findings must be articulated and presented with reference to appropriate and relevant theoretical and methodological perspectives. In order to provide a response to the argument that the study findings are not a consequence of a single perspective, method or individual bias, triangulation using different perspectives and multiple data sources can be used to enhance credibility (Ohman 2005; Adami and Kiger 2005).

Data triangulation involves cross checking data from different sources (e.g. interview data with observation data) or examining for consistency over time (using the same approach at multiple time points), or comparing multiple perspectives. Multiple researchers or investigators can be used to review the study findings to reduce bias (investigator triangulation) or multiple theories used to interpret the data (theory triangulation). The consistency of findings

can also be examined by using different data collection methods (methodological triangulation) (Magnusson et al 2005). In this study, investigator triangulation was not possible (as a PhD study and conducted by a lone researcher) although the findings were examined and discussed with others (supervisors and the patient and carer advisory group (for the pilot study)) as well as the participants themselves to check interpretation.

The purpose of qualitative research is to give in-depth descriptions rather than suggesting the findings indicate certainty. Consequently, the findings are examined for consistency over time (using the same approach at multiple time points), cross checking the data from different sources (e.g. journal entries with interview data), and comparing multiple perspectives. Using two main approaches (journal entries and interviews) within the same methodological tradition is consistent with a methodologically triangulated design approach. The researcher's own personal values, perspectives and assumptions are interlaced throughout the study and the impact of this is explored at all stages of the research process and within the findings.

4.7.4 Data analysis and interpretation

Analysis of data necessitates a systematic and coherent approach (Jirwe 2011) undertaken with sufficient "*sensitivity and insight to unpick meaning and demonstrate that meaning in the way the storyteller intended*" (Dibley 2011: 13). The approach taken to data analysis in order to demonstrate credibility, coherence and trustworthiness was discussed in the previous section and a full account of data analysis is given in Section 5.4.3. In

addition a reflective account of analysis and interpretation is also provided in section 7.6.

The study was concerned with the perceptions of NQNs and as no direct observation of their behaviour in practice was undertaken, the role of coding during data analysis was important. Throughout data analysis, a deliberate reflective and reflexive analytic approach was used that moved between the data produced and the researcher's subjective perspective in order to create meaning.

Analysis of the data was conducted in a systematic way focusing on the chronological order in which the data was collected. For this study, the approach taken had an "*inbuilt progression and chronology that offers a clear narrative route*" (White et al. 2014: 375). In addition, establishing a structured method with a fixed number of sets of steps was less idiosyncratic and more methodologically driven (Giorgi 2011). This necessitated moving back and forth between writing the analysis and returning and re-returning to individual pieces of data; dwelling in, with, and away from the minutiae of data simultaneously. This immersion was a necessary and essential part of living with the data and striving to understand and make sense of the connections. This approach to analysis then was to some extent informed by and congruent with that of IPA (Bazeley 2013) although with some modification.

For each participant, preliminary analysis of data commenced with the directed reflections (one and two) and then the interview data. Thus, for each participant data was first analysed in individual segments i.e. the first then the second directed reflection and then the interview. This enabled the creation of an individual story for each of the fourteen participants. The transcripts were read repeatedly to facilitate becoming embedded in, and involved with, the text prior to identifying possible meanings (Moore 2012). Both the transcribed data and the audio of the interviews were attended to in order to consider the subtle pauses, nervous laughs, intonation and emphasis as well as the written word. During analysis there was a particular focus on the language participants used (written or verbal) consistent with the symbolic interactionist methodology (Charon 2010).

Then the data from each of the individuals was re-ordered so that data was collated in terms of each transition point. Three data tables were created prior to integration. Transforming the individual stories into collective stories of transition involved moving from a process of dwelling ‘on’ to dwelling ‘in’ the data and exploring the key ideas and concepts that had emerged. The creation of three data tables representing each of the transition stages assisted in the identification of incongruities, outliers, similarities and differences and the ‘describe, compare and relate’ approach advocated by Bazeley (2013) was used. Writing up of the preliminary analysis for each stage was key to determining key ideas, concepts and preliminary themes so that they could then be clustered to provide an overview of the data within

each of the stages. The collective stories were then used to form the concept maps for each transition point to illustrate the core themes.

This multi-layered approach to analysis is congruent with the symbolic interactionist approach that demands regularly returning to the data during interpretation and will allow for data saturation prior to integration.

4.8 Conclusion

The gaps identified in the evidence base informed the development of the questions posed at the start of this chapter, and then the subsequent philosophy, methodology and design. Two key approaches from within the same methodological tradition (participant directed reflections, semi-structured interviews) were chosen to provide coherence and integration throughout the study. This ensured that the approach to data collection and analysis remained aligned to the chosen paradigm and philosophical perspective. A qualitative longitudinal study using an interpretative enquiry framework informed by symbolic interactionism was proposed given that the purpose of the study was to explore NQNs perceptions of particular phenomenon within a particular context. The social, cultural and environmental context of the participants' experiences was considered relevant to understanding the meaning of CCPB (Earle 2010) and the interaction between the researcher and researched remained pivotal to the approach taken.

Chapter 5: Study procedures

5.1 Introduction

This chapter provides an overview of the key procedures undertaken to explore the perceptions of culturally competent practice behaviour by NQNs. The chapter commences with key lessons learnt from the pilot study and is followed by a discussion of the key ethical issues relevant to the study. An overview is provided of the main study procedures including access, recruitment, data collection and analysis. The chapter concludes with a reflection on some of the key challenges experienced whilst undertaking the study and offers explanations and justifications that may account for these.

5.2 Lessons learnt from pilot study

A pilot or feasibility study can support a number of important functions prior to undertaking the main study (Halberg 2008) including an opportunity to try out particular research methods or identifying potential difficulties that may be faced (Kim 2011). Importantly, a pilot study can pre-empt some of the challenges ahead and allow for adjustments and revisions to be made prior to the main study. Many pilot studies are never published (Arain et al. 2010) even though the experience gained can be relevant to other researchers in the field (Secomb and Smith 2011). Pilot studies are commonplace in research that use quantitative methods (Thabane et al. 2010) although the term ‘pilot study’ does not routinely feature in the literature on qualitative approaches. Increasingly the potential value of undertaking a pilot study has

been recognised by qualitative researchers (Sampson 2004; Kim 2011; Secomb and Smith 2011; Jessiman 2013).

Pilot study generally refers to a mini version of the main study used to test whether the mechanisms of the main study would work as planned (NIHR Evaluation, Trials and Studies Coordinating Centre (NETSCC) 2014). All research (quantitative or qualitative) requires background preparatory work, and re-examining interview transcripts to inform the interviews that follow is in a sense testing out the processes and procedures (Secomb and Smith 2011). The purpose of undertaking the pilot study as part of this qualitative PhD was three-fold. Firstly, to determine whether the planned recruitment approach was sufficient to generate volunteers (Secomb and Smith 2011). Secondly, to test out the data collection tools and methods in practice to ensure that participants understood what was being asked of them (Jessiman 2013). The third reason was to reflect upon and test out personal skills and abilities as a researcher and consider whether further personal development or training was needed prior to the main study. Therefore, undertaking the pilot study provided experiential learning in the chosen methods (Kezar 2000) as well as an opportunity to explore and develop reflective skills (Kim 2011).

As the purpose of the pilot study, the risks and potential benefits are different from that of the main study, it was important that ethical approval was obtained (Thabane et al. 2010). A similar but smaller target population was used (Halberg 2008) and pre-registration nursing students from a HEI not involved in the main study were approached to complete one directed

reflection and an interview. Following ethical approval (February 2014) information was placed on the HEI's virtual learning platform. Two prospective participants responded to this request and a third responded following a reminder email. As five participants were sought for the pilot study a formal presentation was then given to the cohort which generated five further responses and of these five, two students finally participated.

All participants were then followed up by a phone call and then the consent form was emailed to them for completion. The directed reflection was sent to participants after receipt of the consent from and a convenient time and date was arranged to undertake the telephone interview. During the interview, participants were specifically asked for feedback on the directed reflection. Five participants completed a directed reflection and four were interviewed and all participants were female.

In summary, changes to the main study included a revised and more comprehensive approach to recruitment (Harris et al. 2008; Secomb and Smith 2011; Kaba and Beran 2014) and minor changes to the data collection tools (directed reflection and interview topic guide) to enhance their readiness for the study (Smith 2008; Arthur et al. 2014). In relation to recruitment, the overall approach was considered sufficient to generate volunteers although it was recognised that securing access and recruiting had taken longer that initially anticipated and converting interest into involvement would require repeated contact with participants (Kaba and

Beran 2014). Consequently, additional time was built into the main study for this stage of the research to accommodate this.

During the interview, participants were asked specifically about the readability and comprehension of the directed reflection template and whether they needed any additional information in order to complete it. All five participants interviewed responded positively to this question. The reflected direction appeared to be a familiar tool to participants as it was used for reflective practice and assignments in pre-registration nursing (Bulman et al 2012). In relation to the interview topic guide, participants appeared to be able to answer the questions asked, however the ordering of the interviews needed reconsidering. The topic guide had originally commenced with general questions about their experiences and understanding of CCPB before proceeding to a discussion of the directed reflections provided. As the interviews commenced, participants began immediately talking about the examples they had shared facilitating discussion of the topic and acting as a natural icebreaker in the interview (Smith et al 2008). This then led easily into additional questions about the example provided so that clarification could be sought in terms of concepts or abbreviations used and additional information sought. The interview topic guide was consequently changed to reflect this.

The pilot study was also useful in confirming the suitability of using email and telephone (rather than face to face contact) as the primary means of communication with participants (Berry and Bass 2010). Email was used

initially but once telephone contact had been established text messages proved useful for communication. Email however was beneficial for sending out the directed reflections and these were returned electronically. Of the five directed reflections sent to participants, four were returned within 7 days of receipt and one was returned within 14 days following a text prompt.

During the pilot study experiential learning in undertaking telephone interviews was also important. Having previously undertaken only face to face interviews, telephone interviewing skills required development. This included the importance of giving regular verbal encouragement to the participant as non-verbal means (e.g. nodding, smiling) were not available. Becoming familiar with and competent in the use of telephone interviewing equipment was also an important learning experience. The pilot interviews lasted between 20 and 40 minutes and consequently, the main study information sheet stated that the interview would take between 30 and 40 minutes.

The pilot study and the subsequent amendments prior to the main study are discussed in more detail in the following published paper;

Wray J, Archibong U and Walton S (2016) Why undertake pilot work in a qualitative PhD study? Lessons learnt to promote success. Nurse Researcher. 24, 3, 31-35 http://journals.rcni.com/doi/10.7748/nr.2017.e1416)

5.2.1 Role of the Patient and Carer Group

Ensuring that patients and carers are actively involved in research is considered to improve both quality and relevance of health research (Brett et al. 2012) and is a central tenet of ethical research practice and delivery within the UK (INVOLVE 2015; Crocker et al. 2016). Prior to the pilot study commencing, feedback was sought from a patient and carer group based in the host HEI regarding the study focus, aim and proposed methodology. A presentation was given to the group and four people agreed to provide support and feedback during the study. Two people who described themselves as patients and two people considered themselves as carers. Meetings were held with individual volunteers to discuss the study in more detail and identify their preferences regarding contribution and engagement. The directed reflection was initially drafted up based on examples used previously in pre-registration nurse education for reflection on practice and the interview topic guide was developed following the literature review (Aveyard 2010).

The volunteers gave initial feedback on the draft template for the directed reflection and the interview topic guide in terms of structure, language used and the questions and prompts to ascertain comprehensiveness, readability and accessibility. Following this feedback, revisions were made to the introduction of the directed reflection. This included more information and context to help participants better understand how to complete this and the

purpose of providing the information. Following completion of the pilot study, two members of the group each examined a completed directed reflection and one person examined an interview transcript. Through discussion at individual meetings, feedback was sought as to their interpretation of the information provided by the participants and whether this was consistent with my own perspective. Proposed amendments were also discussed. This added a further check to the trustworthiness of the study, the appropriateness of the directed reflection and interview topic guide and the study procedures. The role of the patient and carer group is further considered in Section 5.5.6.

5.3 Ethical considerations

Gaining ethical approval via an appropriate ethics committee was a necessary pre-requisite, this approval however represented a starting point in ethical decision making, as good ethical decision making should occur throughout. All research involving human participants must be conducted to the highest ethical standards and in accordance with relevant guidelines (DH 2005; RCN 2009; ESRC 2015). These key guidelines encapsulate principles central to good ethical practice in research including the participants' right to be fully informed, not to be harmed and rights to privacy, anonymity and confidentiality. Applying these general principles in practice within a quantitative study required constant reflection and review as the study progressed (Hammersley and Traianou 2012). As Webster et al. (2014) pointed out, "*in qualitative research, decisions are taken dynamically as the*

study evolves, and researchers cannot predict everything from the outset" (2014: 82). Ethical decision making must inform and shape each subsequent step in the research process to ensure participant rights and protections are maintained. In addition, method-specific ethical issues may arise due to the nature of the methodology involved and the data collection approaches chosen (Hammersley and Traianou 2012; Houghton et al. 2010).

Whilst the aforementioned guidelines all provide suitable advice when conducting research, the RCN 'Research Ethics: Guidance for Nurses' (2009) in combination with that of Hammersley and Traianou (2012) recommended for qualitative specific studies informed the approach for this study. As a nurse, nurse researcher and qualitative researcher, the combination of professional and method-specific guidance was a valid and suitable framework to guide ethical decision making throughout the study.

5.3.1 Ensuring consent

The requirement to ensure informed consent is primarily moral but increasingly shaped by regulatory demands within health and social care research (Miller and Boulton 2007). Ensuring the informed consent of participants is a central tenet of ethical research guidance and it is important that this is not seen as a one-off event but a continuous on-going process (Webster et al 2014). Within qualitative research, the researcher must be "*constantly mindful of the ongoing impact that the research might have on those involved*" (Houghton et al. 2010).

An important consideration in relation to consent is whether participants' are able or competent to give consent i.e. make an informed decision based on the information shared as to whether to be involved or not. Discussion regarding capacity in research ethics has tended to focus on involving vulnerable groups whose mental capacity may be temporarily or permanently impaired. For this study, as the sample comprised nurses (at pre and post qualification level) capacity to consent as defined by the Mental Health Act (2007) was assumed. Capacity cannot however be understood purely in terms of a participants' intellectual capacity to understand the information. For example, participants' may have the capability to give their consent but their ability to give informed consent can be compromised if they feel under an obligation to take part (duress). This issue was considered relevant to this study as the researcher was an occasional lecturer within the institution from which some of the participants were recruited. Undertaking research with students who are enrolled on a programme of study in a faculty in which the principal investigator is also employed poses particular ethical challenges. Whilst the researcher had no personal relationship or contact with any of the target cohorts, student nurses may be described as a potentially vulnerable group as they are a 'captive' audience (Anderson, 2011; Clarke and McCann 2005). As recruitment took place through the host institutions' email system, participants may have felt under an obligation to participate. To remedy this potential risk, it was made clear to participants both verbally and in writing that participation was voluntary but that non-participation would not in any way impact upon their current and, or future studies or professional practice.

Another ethical issue to consider was that of undue inducement as at the conclusion of the data collection period, participants were given a thank you gift (a gift voucher worth £30). There are differing opinions amongst the academic research community in healthcare as to whether it is acceptable and, or appropriate to pay research participants (Graham et al. 2007). Payment in the form of money or a gift could be seen as potentially impacting upon participants' decisions to become or remain involved in the study. The Health Research Authority (HRA) (2014) guidance recommends consideration of "*whether the payment is proportionate to the "burden" imposed by the research*" (2004: 2). The gift vouchers were given to participants to acknowledge the contribution of their time and effort and were intended as a courteous and respectful token of gratitude. In order that this could not be construed as undue inducement, participants were not informed of the gift at recruitment, consent or data collection stages. When participant involvement in the project was complete i.e. after the final data collection point, a thank you card with the enclosed vouchers were then sent.

As advocated by Webster et al. (2014), consent requires providing participants with recurrent opportunities to review their consent and agreement to participate. Participants were given detailed information sheets (See Appendix 5) outlining the purpose of the study, the implications of involvement, and their rights to confidentiality, anonymity and withdrawal. If participants volunteered to be involved in the project they were asked to sign and return a formal consent form to indicate that they understood the nature of the project and what was expected of them (See Appendix 5). They were

also given the opportunity to ask questions about the study and clarify any concerns prior to signing the consent form (Miller and Boulton 2007).

Participants were also reminded of their rights, including their right to withdraw at data collection points throughout the study (Houghton et al. 2010). This right was first stated in the participant information sheet, then re-stated at first contact over the telephone, then again upon completion of the formal consent form and finally at the start of the interview. Being mindful of participants' right to withdraw even after consent has been given requires sensitively managing participant contact. For example, ensuring that an appropriate balance was maintained between regular contact with participants to ensure retention in the study and what could be construed as unwarranted contact and potential intrusion. Therefore, in the event of a participant not responding to an email or text, two further prompts were sent. If no response or reply was received after that point it was assumed that they had exercised their right to withdraw. A thank you email, text, or phone message was then sent clearly stating that they would receive no further contact from the researcher.

5.3.2 Protecting confidentiality

In order to give informed consent to take part in a study, participants must also understand how their confidentiality and anonymity will be maintained (Webster et al. 2014; Houghton et al. 2010). This protection assures participants that all information collected as part of the study will safeguard

their identity. That is, any potentially identifying and, or personal details that might reveal their or another persons' identity will be removed from the data prior to being shared via publication or presentation. Participants were provided with information regarding their confidentiality and anonymity in the study information sheet and at subsequent intervals (for example, at completion of the directed reflection and at interview).

Participant rights to confidentiality and anonymity also extended to all data captured as part of the study. Data was kept in accordance with the Data Protection Act (1998) and secured within a password-protected computer. Each participant was allocated a personal identifying number known only to the researcher and research supervisors. The code used was 'Main Study Participant' (MSP) plus number (1-14) e.g. MSP1, 2 and so forth. This enabled identification during data collection and analysis and allowed differentiation from the pilot study participants (PSP). This unique identifier was used throughout and kept separate from personal details such as participant location, place of work and contact details (email and phone). This coding system can be seen on all text documents in this thesis. All documents were anonymised and if there were any details in the text of the directed reflections or the interviews that might identify a third party, these were removed and replaced by their role (for example, colleague, manager or patient). In accordance with good research practice (RCN 2009), the participants (also nurses) were reminded of the importance of maintaining patient confidentiality when discussing their practice "*Please be careful when you are describing specific situations that you do not provide names or other*

details that might identify a patient or colleague. Just as your confidentiality is protected in this study, it is important that you protect that of your patients and colleagues" (See appendix 5).

5.3.3 Balancing the risk of harm with potential benefit

Informed consent also required participants to fully understand the potential benefits and risks of being involved in the study. In this study, there were minimal perceived potential or actual physical risks or harm to the participant. As all contact and data collection was managed remotely, no face to face contact occurred throughout the study and the risks associated with location and the lone researcher were not pertinent (Gagnon et al. 2014). One of the benefits of the research design and methods employed was that the personal safety of both participant and researcher when conducting data collection were protected (Webster et al. 2014). Participants were asked to contribute approximately two and a half hours of their time over the duration of the data collection period (8 months). It was recognised that this represented a time inconvenience for participants. However this was divided into three distinct periods of contribution and participant burden was reduced by undertaking the study via telephone (interviews) or email (directed reflections) ensuring that the participants had some control over this. In addition, this requirement of them was clearly stated in the study information sheet.

Potential or actual physical risk or harm to the participant was unlikely in this study, however the potential for participant distress was recognised as a key

concern that required careful deliberation. As Webster et al. 2014 stated "*if researchers are going to delve into people's private experiences, they must be prepared to respond appropriately to distress*" (2014: 96). It is recognised that discussing personal issues or potentially sensitive topics can be challenging for participants as reflecting on personal beliefs, attitudes or behaviours may surface emotional issues or distressing recollections (Dickson-Swift et al. 2007; Elmir et al. 2011).

This was especially pertinent to this study as a discussion of cultural competence as participants were being asked to reflect on their own conscious or unconscious beliefs in relation to diversity and explore the impact of this on their interaction with patients. In relation to the interview, discussing potential sensitive issues can elicit intensive emotional responses (Elmir et al. 2011) and it is the researcher's responsibility to ensure that this risk (even if it is a potential risk) is considered, planned for and managed appropriately. If a researcher is not comfortable discussing a particular topic or subject area they are unlikely to approach or respond to the participant in a way that facilitates support (Webster et al. 2014). However, the research itself is not the source of distress, rather it is the feelings or emotions that may be surfaced by being involved in the research (Ahern 2014).

Consequently, in this study, prior to the interview commencing, participants were informed that they could terminate the interview if they wished at any point or decline to answer a particular question. In addition, sources of

support available to the participant were also detailed on the interview topic guide so that they were immediately available during the interview should the participant become distressed (See Appendix 4). This included points of contact to access counselling support and, or mental health services via an employer, professional organisation and, or the NHS.

The potential benefits of being involved in the study were also shared with participants. Often within the literature on research ethics in healthcare, the focus is on mitigating against risks (actual or potential) and dealing with the process of ethical approval within an increasingly stringent governance framework (Miller and Boulton 2007). Participant benefits, or even the right to be involved is often overlooked or lost in a discourse focused on protection and risk (Webster et al. 2014). The benefits of involvement must be made explicit so that the participant can make an informed decision by assessing the balance of inconveniences and risks with that of the direct or indirect benefits. However, it is the researcher's responsibility to provide information in a clear and transparent manner to inform that decision. The direct and indirect benefits of being involved in the study were explained to participants both in the study information sheet and verbally.

A direct benefit was offered in the form of the IDI report which provided participants with detailed information about their cultural competence and their personal and professional development. For some, having the opportunity to share views and experiences on a sensitive topic can provide

an opportunity for the expression of unexpressed emotions and be cathartic (Elmir et al. 2011). An indirect benefit was the development of research, knowledge and research skills (as part of a PhD) and the potential for future improvement of nursing practice. Whilst some participants may value contributing to academic endeavour and the promotion of knowledge and, or practice, often studies such as this rely heavily on the altruism of participants (Dickson-Swift et al. 2007; Webster et al. 2014). For nurses the motivation to be involved may be influenced by an opportunity to discuss and influence an area of professional value and interest.

These key ethical issues and concerns informed the formal application for ethical approval to conduct the study. Ethical approval to proceed was given by the Humanities, Social and Health Sciences Research Ethics Panel at the University of Bradford on 5th March 2014. Additional approval was subsequently given by the same panel to extend recruitment to other HEI's (on 24th October 2014). For all additional HEI's involved in the study, approval were secured via the institutions' relevant ethics committees prior to formally commencing the study. The procedures followed for this study are described and discussed below prior to a reflection on some of the challenges experienced.

5.4 Study Procedures

The timeline for access, recruitment and data collection was the same for each participant and the procedures followed the same protocol. Data

collection points were scheduled in accordance with the proposed framework of the NQNs 'journey' based on previous research into transition (see Appendix 6: study procedures flow-chart and timeline).

Recruitment for the main study commenced in March 2014 and data collection took place between September 2014 and March 2016. At the conclusion of the data collection period, 28 directed reflections had been completed and 14 in-depth semi-structured interviews were conducted generating 42 segments of data for analysis from 14 participants.

5.4.1 Access and recruitment

Pre-registration nursing students were recruited to the study, prior to the completion of their programmes via three Higher Education Institutions (HEI). Recruitment was initially undertaken within one HEI (HEI (1)) with a specific cohort targeted, however, as recruiting sufficient participants for the study proved challenging, recruitment was extended to an additional cohort within HEI (1), and two other HEI's (HEI (2) and HEI (3)).

Once ethical approval had been obtained, access to the study population was required prior to commencing recruitment (Ritchie et al. 2004). Key skills were needed to negotiate with potential gatekeepers and navigate complex bureaucratic systems (Kaba and Beran 2014). As pre-registration nursing students formed the study sample, initial contact was made with the Head of

School and, or Programme Lead to facilitate access. Once access had been agreed all students were sent a project recruitment email explicitly stating that volunteers are requested for a PhD study via email. The project information sheet was attached and the same information was also placed on the School's virtual learning environment (VLE).

This approach generated limited interest in the study (1 response). Recruitment often poses a number of challenges especially when accessing a volunteer sample (Parahoo 2006; Ritchie et al. 2014). This phase of a study required a substantive investment of time and effort and sometimes for little or no return. However, failure to recruit successfully has implications for the study timeline (McCance and Mcilfatrick 2008) and reliability and validity (Jessiman 2013). Generating enthusiasm and interest in the study was necessary to engage potential participants (Kaba and Beran 2014) and it required sensitivity to participant schedules and demands upon their time (Harris et al. 2008). Therefore with the agreement of the Programme Lead, a short presentation was given to the cohort in HEI (1) during a timetabled module evaluation session. The PhD study was outlined and the implications for participants should they choose to take part. Expression of interest forms were circulated to the students in attendance and this generated some additional interest in HEI (1) (5 responses). A formal presentation was only given in HEI (1) and not in HEI (2) or (3).

Despite being armed with the experience gained in the pilot study, recruitment to the main study proved problematic and additional recruitment

strategies had to be implemented to maximise participation. First, three alternative institutions delivering pre-registration nurse education were contacted to initiate recruitment (HEI, 2, 3 and 4). Ethical approval to proceed within these institutions was applied for and granted. However, within one HEI (HEI 3), gaining access to the target population proved problematic and as a consequence information was not sent to eligible participants within the timeline for study recruitment. To supplement these on-going recruitment activities, and as an alternative to going directly via academic institutions, the study information was also shared via two on-line forums to raise interest in the study. Table 1 provides an overview of recruitment activities and the relative success of each approach.

For the purposes of this study, 'participated' equated with full involvement in the study throughout all stages. A participant was considered withdrawn if they had signed a consent form and subsequently chose not to proceed. Attrition referred to those participants who initially expressed an interest in being involved but did not respond to either phone or text communication when followed up and did not sign a consent form. From Table 1 it can be seen that presenting to the cohort was the most effective approach for this particular study, followed by sending information out via email or placing this on the institutions VLE. Posting information on line was not effective.

Although, peer recruitment (snowball sampling) had not been planned as an approach, some participants were recruited by their peers from within cohorts. That is, they had initially not responded to the project invitation but

had chosen to become involved after their friends or peers had encouraged them to do so. 14 out of the 25 expressions of interest were converted into actual and prolonged engagement with the study. However, 11 participants chose not to pursue involvement in the study despite expressing an interest in being involved.

All participants who responded with an expression of interest were contacted directly by the researcher via email within 2-3 days thanking them for their interest. A time was then arranged for a follow up phone call to provide participants with the opportunity to discuss the project information and ask questions prior to completing the consent form. If participants agreed to become involved in the study, they were then emailed the consent form and asked to sign and return the form. They were offered the option to complete and return via email or by returning a printed copy and a stamped addressed envelope was supplied if required. In signing the formal written consent, participants indicated that they understood the nature of the project and what was expected of them including the right to withdraw (Houghton et al. 2010).

5.4.2 Data collection

Upon receipt of the signed consent form, participants were provided with information regarding completion of the IDI if they wished to pursue this opportunity. This included a link to the website, a unique username and password to access and complete the IDI and the contact details of the IDI administrator. They were informed that once the IDI had been completed they would be contacted by the IDI administrator to discuss their

individualised feedback. Despite this being offered as a potential benefit for involvement in this study, this was uniformly not taken up by participants and the potential reasons for this are discussed in section 7.6.3. Next, participants were sent the blank template for completion of the directed reflection via email. Participants were sent the directed reflection to complete at the two key transitional points as shown in Appendix 6. The first directed reflection was sent at two months post consent and participants were asked to return these within two weeks. Maintaining regular contact with participants was important to encourage continued engagement in the study (Berry and Bass 2012) and a reminder email was issued three days before the two week deadline if the directed reflection had not already been received. In those cases where the directed reflection was not received within the stated deadline, a reminder email was sent and this approach proved sufficient in all cases to ensure completion of the reflection within a four-week timeframe.

Following receipt of the completed directed reflection each participant was sent a thank you email or text. They were also reminded when to expect further contact from the researcher to facilitate continued engagement in the study (Webster et al. 2014). As the next directed reflection was not due for completion until the second transitionary point at months 5-6, all participants were contacted twice in the intervening period. These emails were sent to thank them for their continued support of the project and remind them of the next stages of their involvement as regular contact and diligent tracking of each participant improves the likelihood of retention (Kaba and Beran 2014).

The procedure for sending out the second directed reflection and following up participants mirrored exactly that of the first. After the second directed reflection had been returned, participants were contacted again and informed that they could complete a 2nd IDI if they so wished. As before, the contact details of the certified IDI Administrator were sent with the web link, and unique username and password.

An email and text was then sent to participants to remind them of the final stage of their involvement and organise a suitable and convenient date and time to undertake the telephone interview. As the participants were in employment and worked shift patterns, organising interviews required tenacity (Kaba and Beran 2014), and flexibility and adaptability (Jessiman 2013). These were negotiated with the participants over email or via telephone or text and took place at between 8 and 9 months post qualification. Once the interview date and time was agreed with the participant, confirmation of this was sent by email and text.

Three days before the scheduled interview date, participants were emailed and texted a reminder of the time and date agreed. They were also sent copies of the directed reflections they had completed with a reminder that these would be discussed during the interview. On the day of the interview, participants were sent a reminder text ten minutes before the interview commenced to ensure that they were prepared. Prior to conducting an interview, it is important that the researcher is mindful of 'the space and place' (Gagnon et al. 2014) of both interviewer and interviewee. Participants

were reminded to ensure they were in a suitable environment and location for the interview to take place i.e. a private space free from distractions (Yeo et al. 2014). All participants were at home when the interviews were conducted. The interviewer used that pre-interview time to re-read the interview schedule and annotated directed reflections, test the equipment and prepare the physical area to minimise potential distractions and intensify focus.

At the agreed time, participants were called via the telephone and participants were asked if were happy to proceed with the interview. If the time or date was no longer suitable, an alternative time that day or another date was arranged. If the participant agreed, the interview commenced with a reminder to participants of their rights and that the interview was being recorded (Webster et al. 2014). The semi-structured interview comprised two main sections; the first section related specifically to the directed reflections and second section had four topic areas (experiences, skills, competencies, enablers and limiters) reflecting the study aim, objectives and research questions. The interviews were conducted using the format, topic guide and questions shown in Appendix 4.

In each interview, the approach taken was initially question-focused to clarify any issues arising from the completed directed reflection and then developed into a more conversational style whilst still adhering to the topic guide and key questions. It was anticipated that the interviews would last between thirty and forty minutes based on the pilot study experience. 14 interviews were conducted in total and the interviews lasted between 19 and 41 minutes (see

Table 3) with an average of 31.6. This appears to be consistent with other studies using telephone interviews and is an appropriate length of time in which to capture data of suitable quality and richness (Carr and Worth 2001; Sturges and Hanrahan 2004; Harris et al. 2008; Ward et al. 2015). All interviews were recorded with the consent of the participant using a digital tape recorder. Brief notes were taken immediately post interview to reflect on the interview and as aid to analysis post transcription (Arthur et al. 2014). Transcription of the audio data was undertaken within 48 hours. A thank you email or text was sent to participants immediately following completion of the interview.

A thank you card with gift vouchers enclosed was sent to all participants within four weeks of the interview. Participants were reminded that their involvement in the study was now complete and they were offered the opportunity to receive copies of any publications or further updates if they so wished.

5.4.3 Data Analysis

A structured approach to analysis was necessary "*to impose some order on the often large volume of data that are collected*" (Clayton and Thorne 2000: 1616). Prior to the interviews, preliminary scrutiny had been undertaken on the directed reflections provided by participants. These has been read and re-read and notes made directly onto them using the following;

- Requires clarification (e.g. terms used, abbreviations, clinical words or jargon)
- Requires more information (elaboration of thoughts or feelings)
- Requires more information (behavioural descriptions /practice behaviour / nursing competence)

This was to enable researcher interpretation to be explored in the interviews and clarification of terms and understanding addressed. In order to classify and rank interpretations of data and examine congruity and incongruity between the perceptions of NQNs over time a data management and analysis approach was used (Spencer et al. 2014) which necessitated 'living with the data'. Clustering and categorising the data, examining concepts and themes as well as defining relationships between and among concepts formed part of the analytic process (Holloway and Todres 2006). All data was analysed by interrogating the data to look for the development of emergent themes and assessing their importance through repetition of coding (Priest et al. 2002; Woods et al. 2002; Elo and Kyngas 2008). The study design informed by the conceptual journal of the NQN also shaped the approach to analysis, its progression and steps (White et al. 2014), adding structure and a coherent process (Giorgi 2011). The 'read, reflect and connect' approach advocated by Bazeley (2013) was initially used to reflect on the data. Analysis was undertaken in the chronological order of the transition journey for each individual participant.

Multiple layer analysis and interpretation was undertaken prior to data integration using an adapted approach to Interpretative Phenomenological Analysis (IPA). However, analysis in IPA generates codes or themes directly from the data rather than using a pre-determined theory and identifying codes to apply to the data (Pringle et al. 2011). IPA would be congruent with a grounded theory methodology or in this case an interpretative analysis approach informed by symbolic interactionism. The approach to analysis used however could not be described as purely IPA as it was also flexible and multidirectional (Finlay 2014). Themes were identified directly from the data (traditional IPA) however codes were also applied to the data using a predetermined theoretical and methodological perspective. This did not include the application of a priori codes as such, predetermined in this sense referred to the already accepted conceptual (transition journey) and theoretical frameworks (DMIS) that had informed the study throughout.

The six key phases of analysis indicated by Braun and Clark (2006) was used. In phase 1 (getting to know the data) notes are made, ensuring familiarity with the data (both audio and written) and reflecting on the interview itself. In phase two (generating initial codes) some initial codes for the data are generated and these related to immediately obvious concepts and characteristics. An example of this would be ethnicity, age, or gender of the patient being discussed. This phase can be compared to that of Holloway and Todres' (2006) third stage (coding the data) and this was done for each interview.

The coding approach was initially open (1st level) and explored responses to the key questions and, or topic guide themes. Items, phrases or words were noted in response to each key topic area and then in phase three (searching for themes), codes were collected together into themes by searching for patterns and regularities and all data pertinent to that theme was gathered together. This provided a wider perspective on the data, some codes were evident in all transcripts whilst others featured rarely and these were combined or divided up to create broad overarching themes and subthemes. In the next phase (four) (reviewing themes), the themes were examined in relation to all the codes indicative of that theme and codes were examined to ensure that they were placed in the appropriate theme (and where necessary the original transcripts re-examined). If necessary, some codes were moved or identified as a comparator or contrasting code or obvious outlier (Silverman 2011).

As recommended by Patton (2002) two key indicators informed this phase; internal homogeneity and external heterogeneity. The former referred to the extent to which data contained within each theme were seen to be related, similar and connected. The latter related to whether the theme was considered distinct and whether when viewed as a whole provided an accurate and coherent reflection of the whole dataset. This was then revised and refined in phase five (defining and naming themes).

In phase five the ‘overall story’ for each of the transition points was generated and included emergent and cross cutting themes as well as inconsistencies. These were generated into visual representation of the data (see appendixes 9-11). Braun and Clark’s (2006) phase six ‘producing the report’ required telling the ‘story’ of the data. That is, how it related to the study aim, objectives and questions and integrated with relevant literature to frame the interpretation and explanation. This final phase forms the thesis discussion section (see Chapter 7).

This multi-layered, cross-cutting approach was undertaken to ensure the ‘story’ generated by the data was congruent with the symbolic interactionist approach which requires regularly returning to the data during interpretation and also facilitates data saturation prior to integration (Mason 2010; Ritchie et al. 2014). During the final phases of analysis and integration of data, the notes that had been made onto the directed templates and reflective notes made immediately post the interviews were used as an additional source to check and re-check the themes. These final phases particularly involved significant time and immersion in the data in order to provide a comprehensive and coherent picture or ‘report’ (Braun and Clark 2006).

Throughout and consistent with the symbolic interactionist approach, a key focus was the words participants used and to assist identification of manifest content (whereby participants' actual words form concepts) in addition to latent content (whereby concepts are derived from my interpretation of

participant responses). Interpretation forms part of the process of analysis as the researcher is instrumental in determining the generation of codes that form part of the key categories. Although, participant words or phrases will inform this, the researcher is active in the selection adhering to the notion of symbols and in particular the words people used (Charon, 2010).

Key to this process was the generation of data tables that reflected each individual narrative and captured the three key sets of data per participant (two directed reflections and one interview) into a coherent interpretation; the individual story. Appendix 7 provides an illustrative example of one of the individual data maps created using the 'read, reflect and connect' approach recommended by Bazeley (2013). Preliminary notes captured ideas on thoughts on the data and illustrative quotes were added to ensure the comment or note remained connected to the words of the participants. Additional notes were then added to link ideas with the study objectives and questions, the literature and methodological and theoretical framework. Colour coding was then added to differentiate between key elements within the individual story. A selection of notes were also added to the bottom of the data table from the researcher's reflective journal to further assist in organising the data. These data tables formed the preliminary stage of analysis, and from these individual stories, group data tables were created. That is, the data from all fourteen participants was then re-grouped to comprise three transition point data tables (TP1, TP2 and TP3) and create the collective stories. The collective stories were used to generate the maps shown in Appendices 8-10.

5.5 Reflections on study procedures

This final section concludes with a reflection on some of the key challenges experienced whilst undertaking the study and offers some thoughts and explanations that might account for these.

5.5.1 Access, recruitment and retention

As recruitment commenced within the HEI's, initial contact was made with the Head of School and, or Programme Lead to facilitate access. However, communication was also needed with a number of other academic and administrative staff to ensure that information was eventually sent to eligible participants. Identifying the most appropriate person proved to be a key challenge during this stage as this person was not always the most senior in the organisation. The time delay between initial contact and identifying the person who would eventually send out information necessitated an open and on-going communication chain involving an extensive number of different people within the organisation.

Gatekeepers in nursing research can sometimes be portrayed in a negative light as they can control and even prevent access to the target population (Ritchie et al. 2004). In this study, it was recognised that although access have proved difficult, gatekeepers did provide an additional layer of participant protection as the researcher was not able to contact the participants directly (Webster et al. 2014). However, despite repeated contact with some individuals, emails were not always responded to and in one HEI

information never went to potential participants. Whilst frustrating to encounter this, it was recognised that in the study that I was reliant upon the goodwill of others (academic staff) and gatekeepers "*have the power to grant or withhold access to potential recruits"* (Jessiman 2013: 20). However, failure to respond to my request for help may well be a reflection of other more pressing demands upon people's time rather than a deliberate decision not to support the research. Equally, this may be that this represented a failure on my part to generate interest in the study and, or topic area (Kaba and Beran 2014).

During the recruitment phase of the project there were challenges in ensuring there were sufficient numbers of participants. Despite the lessons learnt as part of the pilot study expressions of interest did not always convert into sustained involvement (Kaba and Beran 2014). Recruitment was extended to other institutions and additional cohorts and this amendment to the approach was seen as necessary and essentially pragmatic. In order to meet the study aims and objectives, sufficient volunteers were needed for the study to generate enough data to achieve saturation during analysis (Mason 2010). As all contact was made through virtual means (email, phone) there were no perceived difficulties with maintaining contact with participants placed at a distance from the researcher. Indeed it had been premised at the start of the study that although the participants were from a single host HEI, they were likely to be dispersed geographically post qualification. For every additional HEI involved it was recognised that the pre-registration nursing programme within each institution may vary slightly and thus the educational experiences

of the participants were likely to be different. This is further discussed in the limitations section of the thesis.

Extending the recruitment approach to target other institutions and cohorts had consequences for the study timescale (McCance and Mcilfatrick 2008). Data collection was initially expected to be completed within 12 months, however this was extended by another 8 months. Extending the study timeline due to recruitment failings is not uncommon (Jessiman 2013; Kaba and Beran 2014). Fortunately for this study, this extension did not prove particularly problematic as there was sufficient time to accommodate this.

Challenges with recruitment may also be a consequence of the topic not being perceived as interesting. Recruiting participants who are student nurses into a study that was not connected to their immediate studies or assessment can be problematic (Secomb and Smith 2011) and this may have affected the decision of some students as to whether to participate or not. Issues related to equality and diversity are often perceived as non-essential, or a non-clinical priority or core business in the NHS (Shared Intelligence 2012) and engaging in a project on cultural competence may not have been seen as a priority. NQNs who completed the online Flying Start Programme, designed specifically to support transition, viewed the equality and diversity module as the least relevant module, and were least likely to complete it (Banks et al. 2010). NQNs may not have considered the topic of value, relevance and importance to their nursing practice and this may well account for their reluctance to engage with the topic area upon qualification.

Conversely, interest in the topic matter itself may have influenced the decision of those participants who chose to be involved. This study used the term cultural competence throughout and this has been previously associated primarily with race, ethnicity and, or religion. Participants may have felt that this topic was not relevant to them personally as well as professionally. However, this association could have been positive and facilitated involvement or negative thus discouraging participants. Participants may have considered that they were sufficiently informed about cultural competence through their educational preparation and did not require any further information. Whilst a formal presentation to the one of the cohorts did provide an opportunity to connect the concept of cultural competence to the wider debate within the NHS regarding compassion, dignity and respect (DH 2015), this was not the case for those cohorts that were contacted only via email and, or the VLE.

However, if participants were either put off the topic or did not consider it useful or relevant they were unlikely to volunteer in the first place. This does not necessarily account for those students who expressed an interest to be involved in the study but did not progress to full participation. It is likely that, other factors were relevant in understanding attrition and withdrawal. The participants were recruited whilst still a student within an academic institution and initial expressions of interest may be a consequence of their desire or motivation to engage in activities they perceive as beneficial or relevant to their student status. However, as they complete the programme and

commence a new role and life as a qualified nurse, they might no longer associate with their previous identify of ‘student’ (Currie et al. 2010). Thus, they may no longer feel the desire to engage with and be part of work or activity that they perceived as associated with their former status and identity.

In addition, it is recognised that as students transition into the world of work they experience a period of high anxiety and stress (Deasy et al. 2011; Whitehead et al 2013; Edwards et al. 2015). This phase is generally seen as a difficult period of time for NQNs and participants may have had more important considerations as they acclimatised to their new role and employment. Therefore initial interest may have been superseded by other more pressing demands and challenges. NQNs entering this demanding environment and accommodating their change in role and status may well not have the time nor the inclination to engage with this (or any other) study.

Finally, retention poses particular challenges when a study requires participation over a period of time (8 months) and with multiple contact points (Webster et al. 2014). However, it should be noted that for this study, ensuring continued engagement was not problematic once participants had moved past the first data collection point. Three participants withdrew from the study and of these, one left the nursing profession altogether, one left practice and returned to education and it is not known why the third choose to discontinue involvement. For those potential participants who expressed an interest in the study but did not pursue this, it was not possible to

determine reasons as they were considered to have exercised their right to withdraw and not respond to communication.

5.5.2 Use of email and telephone to maintain contact and collect data

The benefits and challenges of using email, telephone and, or text communication formed an important consideration when undertaking the pilot study (see Wray et al. 2017). Email was initially used to send out information to potential participants as this was the preferred communication approach for all the HEI's involved and usual means of communicating with the target group (Berry and Bass 2010; Kaba and Beran 2014). However, once contact had been established, text communication formed the main communication approach as this appeared to be the preferred contact method of participants. Participants responded more quickly to a text than an email (Mason and Ide 2013). Texts were also used to send reminders prior to the interviews and these proved invaluable in ensuring that interviews went ahead as scheduled.

In relation to collecting data however email proved particularly useful. The directed reflection was emailed to participants, who completed this electronically and then returned it via email. Of the 28 completed directed reflections, 12 were returned within 7 days and nine within fourteen days. The remaining seven required additional text prompts and reminder emails. All were returned within four weeks. None of the participants provided a handwritten copy (as was in the case of the pilot study). All participants had

access to a computer and email, and the data was provided in a format that did not require transcription and had no additional resource implications for the participants or the researcher (Novick 2008).

Both email and text contact was used throughout the data collection period to encourage continued engagement in the study. Multiple ways of maintaining regular contact with participants can enhance retention within a study although it is not a guarantee of success (Kaba and Beran 2014). Of the two approaches, email was most effective (and perhaps only effective) when supplemented by a text. Consequently, in this study, email was used primarily for sending and receiving information and key documents whereas text or phone contact was used to facilitate engagement and retention during the data collection phase.

5.5.3 Data collection tools

The justification for using directed reflections as an adapted form of diary methods are discussed in Section 4.7. The experiences of using them in the pilot study was helpful as it provided reassurance that participants were familiar with this approach to reflecting on and recording their nursing practice (Bulman et al. 2012). However, the amount of information provided by participants varied considerably; some were very detailed whilst others contained two or three word responses. This had featured as an issue in the pilot study also and additional prompts had been added into the introduction to encourage participants' to provide more descriptive detail. This still proved

insufficient direction for some participants and as the study progressed this was supplemented with additional email and verbal encouragement to facilitate data gathering. Fortunately, these deficits in information could be addressed during the interview as the directed reflections had not been intended to be used in isolation (Bartlett and Milligan 2015). However, without the interview as an adjunct, their value in provided meaningful data would have been compromised.

In this study, the directed reflections were particularly useful in focusing the participant on the core topic under investigation and were able to solicit preliminary data which could then be further explored (Jackson et al. 2008,). In addition, offering participants an opportunity to take some ‘time-out’ of their busy professional lives to reflect on their practice is a useful and important developmental activity for all nurses. Such reflection is considered important in promoting compassionate and empathic healthcare deliver (Bulman et al 2012). It had been stated on the guidance information for the directed reflection template that participants could, if they so wished, use the reflection as part of their discussions during clinical supervision as an acknowledgment of the value of this activity. In addition, the NMC processes regarding re-validation for nurses has changed in the period since the study started and now qualified nurses are required to produce reflections on their practice in order to continue on the register. Therefore, being involved in the research and generating two reflections that could be used for revalidation could have been offered as an incentive to participants which may have made involvement in the study more attractive.

In relation to the telephone interviews, the experience gained in the pilot study was also useful in relation to improving and enhancing personal competence and confidence. Experiential learning in a research method in which you have no previous experience is invaluable. The researchers' ability to communicate rapport with the participant can be limited by the lack of face-to-face contact (Novick 2008) and this potential limitation is particularly challenging for novice researchers with little experience in this approach (Mealer and Jones 2014). By the time the main interviews commenced, some of the anxieties relating to telephone interviewing (such as equipment failure and how to manage silences) were less pronounced. Additional effort had been made to ensure that contact with participants had already taken place over the phone in the form of a brief conversation about the study so that it was easier to commence the interview rather than it feeling like 'cold-calling' (Sturges and Hanrahan 2004).

Despite this pre-interview contact for all participants, some still required additional encouragement to elaborate and to share their experiences. This is challenging in any interview but perhaps more difficult to manage over the telephone without the visual cues afforded by face to face contact. As a researcher you want people to feel comfortable during the interview with you and encourage a conversational style rather than an imposed interview (Arthur et al. 2014). However, it is worthwhile noting that although telephone interviews require additional and different considerations compared to face to face interviews, my own experience would support that of other authors such as Sturges and Hanrahan (2004) and Trier-Bieniek (2012). That is, telephone

interviewing is not a ‘poor relation’ when it comes to interviewing but is capable of generating sufficiently rich data and offers an equally viable option to the qualitative researcher.

Interviews generate a significant amount of data and transcription is known to be time consuming (Dickson-Swift et al. 2007). However, transcribing the interviews was a useful starting point in understanding the narrative as well as reflecting on the interview itself. Whilst accessing a transcription service can be beneficial and convenient it does not replace the insight provided by listening to the audio of the interviews and personally conducting the transcription. Hearing participant voices, tone and inflection was an important element of connecting with the data (Yeo et al. 2014; Ward et al. 2015) and provided a very different experience and way of engaging with data analysis and interpretation than merely reading a transcript.

All participants had been offered an opportunity to complete the IDI at the start and completion of their involvement in the project as a means to understand their orientations towards cultural difference and commonalities. This did not form part of the data collection procedures but was offered as a potential benefit of involvement as they could reflect upon and consider their own cultural competence and receive copies of personalised reports. However, as the study progressed it became increasingly evident that participants had chosen not to complete this. Only three participants completed an IDI at the start of the project and no participant completed it at the end of their involvement in the study. It may be that participants were

happy to be involved in the project and did not require an incentive of this kind. However, it may be that completion of the IDI itself may have not been appealing. Indeed one participant commented:

"*I did have a look at this but it looked a bit complicated and a bit of a faff*" (MSP 4)

This may well have also discouraged others from completion. However, for one participant the thought of the report itself was off-putting;

"*I clicked the link you sent me and was thinking of doing it but the idea of the report put me off. It felt like I was being assessed or judged or something*" (MSP 7)

If participants completed the IDI they were to discuss the contents of the report with the IDI administrator. This was to ensure that supportive and sensitive feedback was provided and minimised the risk that the participant read and interpreted the report without appropriate support and contextualised understanding. However, the prospect of receiving a report of this kind was sufficient in itself to put one of the participants off. The intention was to ask all participants during the interview whether they felt that there cultural competence had developed or changed during this time with reference to the IDI. As this was not possible, and as it became evident that participants were not choosing this option, participants were asked if they

themselves felt that their ability to interact with and care for patients from diverse backgrounds had changed or developed.

Therefore, there was no external (or objective) reference point for the participants and for the researcher to determine whether there has been a change in cultural competence other than the self-reported perspective of the participant. Although, given that the reports were confidential to the participant and not shared with the researcher, participants could have chosen not to share this information or provide a more positive account of their cultural competence. The IDI had been considered a potential benefit to offer participants, however it was equally recognised that completion of the IDI would facilitate participant reflection on this area of practice leading to the production of focused and rich data. As this was not pursued by participants, whether this would have had an impact on data quality can only be speculated on. It may well be that the directed reflections provided the necessary reflective opportunity and focus. Sadly though, as someone who had completed the IDI and found it beneficial it meant that the opportunity to reflect upon past experiences and assumptions and inform future learning and development was lost.

5.5.4 Reflecting on the involvement of the Patient and Carer Group

At the start of this PhD, support was sought via the host institutions' already established patient and carer group for volunteers willing to be involved in this study. Three volunteers expressed an interest in the topic area and were

actively involved during the pilot study phase of the research (see section 5.2.1). Unfortunately, as the study progressed into the subsequent stages the three volunteers were unable to continue their involvement. For one volunteer, this was a consequence of a deterioration in their own health status, for another an increase in carer responsibilities limited their time and availability. The third volunteer relocated to be closer to their own family. Although contact was maintained with all three volunteers throughout the data collection period, changes in their personal circumstances had resulted in a decline in their involvement as originally anticipated.

The three volunteers had provided their time and insights during the early development of the project and in particular, the pilot study. The study topic area and focus has already been predetermined therefore patient and carer involvement was limited to study design and delivery (INVOLVE 2015). Working with the patient and carer group encouraged the development of ideas related to the directed reflective and the interview topic guide, particularly around the wording of the text within both. Listening to patient and carer perspectives during the development of these improved their accessibility and this is a known benefit of involving patients in research (Brett et al. 2012).

There are a number of challenges to actively involving people in research projects and this study like others failed to undertake this successfully (Omeni et al. 2014). Understanding the personal circumstances and

experiences of the volunteers was an important consideration when the group was first established. This was to help determine training needs and support as well as level and extent of involvement. However, it was not possible for people to sustain their involvement in the longer term and this challenge is acknowledged by others (Crocker et al. 2016). For these three volunteers, disengagement from the project was driven by a change in circumstances and this outcome was therefore unavoidable. However, upon reflection additional volunteers could have been recruited to group to take into account attrition in the longer term (INVOLVE 2015).

In addition, an alternative approach might have been to recruit new volunteers in the latter stages of the project. Unfortunately this was not undertaken due to time constraints during the final stages of the project. Involvement of the public in research does require time and resources and these are not always available to the independent researcher (INVOLVE 2015). In this instance, the volunteers were supported financially by the host institution and received appropriate recompense for their time and contribution. Although the group were not able to continue with their support during the main study, their contribution was essential particularly in the early stages when the study was in development. Also, for a novice researcher there was a substantive benefit in developing skills and learning from the experience of working with the public, patients and carers.

5.5.5 Reflecting on self

The ways in which potential participant distress was approached was discussed in detail in the section on ethical considerations (section 5.3). Whilst this had formed a key consideration whilst applying for ethical approval and throughout data collection and analysis, it was evident that this potential for distress was equally applicable to myself as a researcher. Having been focused on addressing participant distress, I had not considered in sufficient detail the impact of discussing cultural competence on my own emotional responses.

Whilst it would be an exaggeration to refer to researcher 'burn-out' or 'vicarious traumatisation' (Elmir et al. 2009), the comments made by the interviewees particularly when describing what I considered to be less than exemplary nursing practice did have an impact upon me. When interviewing on topics that are especially challenging or traumatic, some form of debriefing is necessary (Dickinson-Swift et al. 2007). In this study, I found the use of the reflective journal (both audio and written versions) was useful to re-visit and reflect upon any areas that were personally or professionally difficult for me as a nurse and, or researcher. In addition, discussing these issues within supervision or with my action learning set provided further opportunities for reflection. Whilst this did not occur often, I was able to reflect upon the reasons why I found some words or phrases used by participants within the interviews more difficult than others. These served as

a way of examining my own sensitivities, assumptions and potential biases. This is further discussed in Section 7.6.

Engaging in qualitative studies of this kind requires the researcher to engage with and interact with the participant to seek meaning. However, the meaning that the researcher ascribes is an interpretation of participant perceptions and the researcher's own assumptions, views and background are influential. Consequently, it is important to have some insight into these potential influences and acknowledge how these impact upon in both process and outcomes in the study. The study required participants to discuss their professional nursing practice, a potential risk envisaged was that participants may recall or report information that could be construed as contravening the NMC Code (2015).

As the researcher was professionally accountable as a qualified nurse, participants were informed of the following "*All information will be confidential to the principal researcher and her supervisors. However if you provide information that may place you or others at risk of harm, or contravenes the Nursing and Midwifery Council's (2008) Code: Standards of conduct, performance and ethics for nurses and midwives then our professional duty obliges us that this information be shared with the relevant person or body. You will be informed if this is the case*". As a nurse, you can be placed in a difficult position as there are circumstances in which your obligations under the NMC Code (2015) will effectively require you to override the participants'

right to confidentiality. As this is important to the participants' understanding of the research, this was clearly stated clearly on the project consent form so that participants were aware of the implications of such a disclosure.

This also provided a useful reminder of the challenges faced by nurse researchers in relation to role boundaries and potential conflicts of interest (Houghton et al. 2010). It is not unusual in nursing research for the researcher to also be part of the same professional group as the participants (Moore 2012). In this particular study I was both insider (as a nurse) and outsider (as a researcher) and whilst the ability to remain somewhat detached and in the researcher role is valuable, arguably achieving full distinction between roles is problematic. These roles and identities are fluid and movement in and out of these identities can change moment to moment depending on the context and circumstances (Kirton and Green 2005).

The relationship between participant and researcher is pivotal in qualitative research and this must be explored to identify potential risks to the integrity of the research. There were no instances during the study in which I was required to intervene as required by responsibilities as an NMC registered nurse. However it was useful for me as a researcher to be aware and mindful of this as I have an obligation as the researcher to the integrity of the research and the participants' rights within that context (Houghton et al. 2010). However, given the possibility of a potential breach of the NMC Code (2015) it was important that I could prepare and if needed, react in an

appropriate way that was supportive of the participant yet upheld my professional obligations. In the circumstances of this study, both researcher and researched had dual roles in that the interviewee is both a participant and a professional nurse and the interviewer is the researcher and a professional nurse. Consequently, understanding researcher positionality (Moore 2012) and how roles boundaries can change when undertaking research is essential for good ethical practice (Hill 2006).

In conclusion, reflecting on the research procedures was an important part of this study and helped to provide some insight into my own views and assumptions prior to approaching data analysis and interpretation. One of the recurrent themes emerging from these reflections and worthy of specific attention is the notion of privilege. In relation to participants, there is the notion of "*affording a privilege by being allowed to listen to stories that were often private and intimate*" (Dickenson-Swift et al. 2007: 340). It is important to understand as a researcher that you have been given access to people's personal lives and that you must be respectful of that privilege throughout the research process. The challenges experienced during recruitment and the relief that followed participant involvement at first overshadowed all else in my reflective notes. Then increasingly, a sense of the kindness and generosity of participants in sharing their views, thoughts and feelings emerged. This helped me to recognise that the participants had allowed me to access information and experiences that were central to my understanding of contemporary nursing practice and some of the challenges experienced by NQNs. Being mindful of this privilege was also relevant to my understanding

of why good ethical practice in important throughout the research process and does not just end with formal consent (Webster et al. 2014). Participants were not obliged to contribute but have given up their personal time and consequently being respectful of that contribution must persist throughout data collection, interpretation and publication.

5.7 Conclusion

The procedures detailed in this chapter provide an account of how the study was conducted with due regard to ethical considerations and the needs of participants. Whilst not commonplace within the field of qualitative research, a pilot study was conducted as preparatory work to help shape and refine the main study. This provided an opportunity to test out some procedural issues related to access and recruitment and engage directly with research methods, developing the personal skills of the researcher and improving confidence. Consequently, the procedures adhered to in the main study had been already tested out and developed, adding to the credibility and trustworthiness of the study.

Chapter 6: Findings

6.1 Introduction

The chapter will commence with an overview of the key characteristics of the participants in this study and then the study findings are described. These are presented in chronological order to reflect each transition stage at which data was collected, that is, at 2-3 months (directed reflection), 5-6 months (directed reflection) and 8-9 months (interviews). Within each of these stages, the findings explore and explain the key themes with reference to the previously stated aim, objectives and questions for the study.

The approach to interrogating the data is documented in Sections 4.7.4 and 5.4.3. Appendix 7 provide an examples of how the data was organised and collated during analysis prior to the mapping of the key findings into a visual format representing each of the key stages. Throughout this chapter, illustrative quotes are used to demonstrate key concepts, themes or sub-themes and to evidence the relationship between the data captured and findings generated. All quotes are prefixed with the participant identifier (e.g. MSP 1, MSP 2, and so on). This chapter concludes with an integrative review that summarises the core concepts and key themes from the findings.

6.1.1 Characteristics of the Study Sample

14 participants were successfully recruited into the study and the demographic details captured from participants including field or branch of

nursing, gender, ethnicity, place of work and recruitment location are shown in Table 2 below.

MSP	HEI No	Gender	Ethnicity	Branch of nursing	Place of work
1	1 (cohort 1)	F	BAME	Adult	Hospice (Private)
2	1 (cohort 1)	F	BAME	Adult	Gynaecology
3	1 (cohort 1)	M	White British	Adult	Medical elderly / rehabilitation
4	1 (cohort 1)	F	White British	Adult	Outpatients clinic (NHS)
5	2	F	White British	Adult	General Surgery
6	2	F	BAME	Mental health	Crisis Team (inpatient unit)
7	2	F	White British	Adult	Community Alcohol / Drug Service
8	1 (cohort 1)	F	BAME	Child	Paediatrics
9	3	F	White British	Adult	Day Surgery
10	3	F	Not stated	Adult	Renal
11	1 (cohort 2)	F	White British	Adult	Plastic Surgery (Private)
12	1 (cohort 2)	M	White British	Adult	Voluntary and Community Sector (Mental Health)
13	1 (cohort 2)	F	BAME	Child	Paediatrics
14	1 (cohort 2)	F	White British	Adult	Orthopaedics

Table 2: Characteristics of Study Participants

The majority of the participants (11) were trained as adult registered nurses (RN's). Two participants were Registered Children's Nurses (RNC) and one participant was a Registered Nurse Mental Health (RNMH). No participants were Registered Nurses for Learning Disability (RNLD), or registered Midwives. From Table 2 it can be seen in terms of gender distribution, 12

were women and 2 were men. In the UK, nursing is a gendered occupation and only 11% of the registered workforce are male (NMC 2016). The sample was therefore not unusual in respect of gender. In relation to ethnicity, 8 of the participants were White British, 5 identified themselves as being from a BAME background and 1 participant chose not to provide this information. Of the 5 participants who described themselves as BAME in terms of ethnicity, both MSP1 and MSP 13 described themselves as specifically from the Asian Muslim community. MSP 8 described themselves as Asian but from a culturally diverse family including people who were described as Asian, British, Welsh and Greek. MSP 2 and 8 both described themselves as BAME but specifically as coming from an African background.

The NMC (NMC 2016) reported that 59% of those on the NMC register considered themselves White British, however 27% of registrants were recorded as ethnic category ‘unknown’. Comparisons are therefore difficult when key data is missing. The ethnic diversity in the sample may be accounted for by the geographical location of the main recruiting area which has a considerably diverse population. Equally, the topic area may have attracted participants from diverse backgrounds who had a personal or professional interest in cultural competence.

Although participants provided some demographic details including their ethnicity, they were not asked to provide further information in relation to family composition or background. However some participants (but not all) spoke specifically about their experiences of diversity in relation to other

characteristics; one described themselves as being ‘an older nurse’ (MSP 4) and the other as was having a family member who was homosexual (MSP 9). The personal characteristics of the participants and the impact of personal diversity on their perceptions and experiences is further discussed in Chapter 7 (see Sections 7.4, 7.5 and 7.7).

All the participants had commenced employment within four months of completing an approved programme in pre-registration nursing in the UK. 11 had commenced employment immediately upon completion of the programme and registration with the NMC, 2 participants had been required to resubmit academic work in order to successfully graduate and had experienced an unanticipated delay in commencing employment. 1 participant had chosen to take a four month extended holiday break and subsequently commenced employment upon their return to the UK. In terms of healthcare organisations, 12 of the participants were working within in the NHS in a range of different settings, 1 was working within a private hospice and 1 within the voluntary and community sector. All were working in the UK.

6.2 The first transition period

The directed reflections provided by the participants during the first few months of employment were characterised by two key interrelated constructs; nursing care and practice and (own) perceived competence and confidence. In relation to nursing practice, participants provided descriptions of specific

behaviours or actions that were undertaken in order to meet the perceived diversity characteristic of the patient. They also provided descriptions of generic behaviours or actions perceived as pertinent to the delivery of care of all patients. Self-perceived competence and confidence in delivering patient care were characterised by uncertainty and anxiety in the first transition period.

Their perceptions of nursing practice (both specific and generic) was dominated by a focus on the core nursing skill of communication and their self-perceived levels of competence and confidence in communicating with patients from a diverse background.

6.2.1. Perceptions of culturally competent practice behaviour

Reflecting on caring for patients from diverse backgrounds, participant descriptions were almost exclusively focused on communication. Six out of the fourteen participants specifically focused on the challenges they experienced when caring for patients in which there were language barriers resulting in communication challenges;

MSP 2 "*Communication was the key issue, she didn't speak very good English and that was a problem for her*"

MSP 3 *"he either refused or didn't speak much English"*

MSP 7 "*He was Polish and his accent made it difficult for me to understand what he was saying. He would shout out in Polish and I didn't know what he was saying or wanted*".

MSP 11 "*I couldn't really understand what she was saying. I did ask her if she could speak English. She said yes but it was obvious that her English wasn't very good*"

In the case of MSP 4, the communication difficulties arose when a family member was used as an interpreter;

MSP 4 *"I wasn't sure whether the daughter didn't understand me properly or that she wasn't explaining it well to her mother or what"*

For MSP 3, the patients' clinical condition (dementia) added to the complexity of caring for an Asian man;

MSP 3 *"He didn't smile or say thank you… he grunted when he wanted another mouthful…he turned away and basically blanked me once more"*

MSP 8 experienced difficulty communicating with a child because of the child's learning disability;

MSP 8 *"I told her hopefully the doctor would be here soon but she didn't say anything so I asked the parents whether she understood. They said yes she*

understood but was scared. So I said to her hello my name is X (name removed) and I was the nurse and I would look after her today. She still didn't say anything"

Participants were acutely aware of the importance of ensuring that they communicated effectively with patients and their families;

MSP 1 *"I just made sure that I discussed with the patient and their family what they needed and how best I could deliver care"*

MSP 3 "I was careful to ask permission before all stages"

MSP 12 *"As a clinician it is important that we listen, non-judgementally. I find that what works for me is to put myself in the shoes of the client*"

For MSP 8 and 13, qualified RNCs who were working in Paediatric settings, communicating well with children was important;

MSP 8 *"When a child has a learning disability you need to make sure that you communicate effectively with them so that they are not anxious and understand what is happening to them"*

MSP 13 "*Being able to communicate well with children it central to establishing a trusting relationship with them and their families*"

Two of the participants provided distinctly different perspectives on communication compared to the rest of group at this stage. MSP 1 gave an account that focused on a patients' family and how they had communicated with them as the nurse (rather than vice versa);

MSP 1 *"I felt angry and upset by some of the comments made by the family about my race (Asian) and religion (they thought I was Muslim – I am not I'm a Sikh)"*

MSP 12 described the impact of a positive communication encounter;

MSP 12 "*The client was tearful and upset, but said that they felt better at the end of the session than they did at the beginning. The client was thankful for being listened too and stated that he looked forward to the next session*"

Participants also described specific communication actions or behaviours that they undertook to respond to their patients' communication needs. This included providing information in an accessible format for a patient with a learning disability (MSP 8) and using non-verbal communication when there was no shared language between nurse and patient (MSP 4, 11) as illustrated below.

MSP 8 “*She told me to give the parents one of the leaflets we have. It’s an info leaflet about the ward in an accessible format with pictures so I took that to them and I showed it to her also”*

MSP 4 *“I think using non-verbal approaches (with the meds sorter) helped us to find a way to communicate better”*

MSP 11 “*I used non-verbal communication approaches more with this patient. Pointing, using gestures and kept my instructions simple*”

The participants provided descriptions of clinical activities they were engaged in e.g. washing and feeding patients, preparing patients for theatre, undertaking routine observations, providing medications, moving and handling, working with parents and families. Participants provided examples of culturally sensitive care specifically to a Jewish patient (MSP 5), a frail elderly woman (MSP 7), a disabled man (MSP 10) and a Muslim child (MSP 13);

MSP 5 “*When it came to their dietary requirement I asked what they ate. The patient stated they did not eat pork*”

MSP 7 “*I got close to the bedside and then I told her that I was going to move her and I would be as slow and gentle as I can.”*

MSP 10 “*I made sure that everything was within easy reach for him, especially the buzzer and his walking stick. I wanted to make sure that he could be independent*”

MSP 13 “*I spoke to both her and her parents and showed them where the information stand was so they could select the information in an alternative language*”.

Acknowledging the specific and individual needs of patients irrespective of their background was seen as fundamental to nursing care and this was characterised by the following statements;

MSP 3 “*reminding myself that he is just like any other patient – in need of my help, kindness and compassion*”

MSP 5 “*For me it was learning how to care for this patient and respecting their needs*”

MSP 6 “*I did this because I think it is important that nurses care for people and do not discriminate against them because of their background*”

MSP 10 “*I tried not to focus on his disability but on his abilities and promote his independence*”

MSP 12 "*It is important to deliver non-judgemental compassionate care because if we do not we cannot expect to gain the confidence or trust from our service users*"

Participants also acknowledged that their own individual perspectives, thoughts feelings and personal beliefs were relevant to the interaction;

MSP 1 *"You have to recognise that all patients are different from you in one way or another. You need to deliver the best care you can and not let your own personal beliefs regarding a patient (or their family) effect the quality of care you give"*

MSP 3 *"It is also important to make sure that any negative feelings you may feel towards the patient on the inside, is kept there and that externally you remain professional at all times and care for them like you would any other"*

MSP 5 "*It is important to care for diverse patients because you learn different things about the patient and is also helps to care better for them*"

MSP 9 "*It about respecting people's religious beliefs even if they seem a bit strange to you*"

MSP 12 *"I thought that this was a difficult session for me because some of the things we discussed aroused personal and professional fears"*

MSP 1 particularly linked this to the NMC Code (2015);

MSP 1 *"It is important that the patient feels that care is delivered with compassion. It is important for the nurse to uphold the NMC standards*"

For the three participants (MSP 1, 6, 14) the importance of being professional related to experiences in which they felt challenged by the patient, or the patients' family;

MSP 1 *"I realised that if I didn't address this with the family I would continue to be angry with them. Although I knew that this wasn't the patients fault I did think that this might impact on the care I was delivering*"

MSP 6 "*Although this patient wasn't very nice I tried to understand and not let my own feelings get in the way of how I delivered care. I was professional at all times*"

MSP 14 "*You have to be professional at all times. Even if you feel upset with the patient you are a qualified nurse and you have to be professional*"

6.2.2. Self-perceived competence and confidence

Participants' perceptions of their own competence and confidence caring for people from diverse backgrounds was a persistent feature of the directed reflections at this stage. Knowledge or lack thereof of patients from particular backgrounds caused participants some concern and this could lead to assumptions;

MSP 2 "*It is difficult when you don't know about a persons' culture because you cannot be sure that you are doing things correctly*"

MSP 7 "*I did the best I could but it was difficult as I did not understand this patient and didn't know whether this was usual for people from that type of background*"

MSP 3 *"I was unsure whether his religion restricted tasks such as these with regards to baring flesh and me as a female seeing his flesh"*

MSP 5 "The patient I cared for was Jewish and had different morals"

Whereas for MSP 8, 9 and 13, this lack of knowledge was also linked to a recognition that they needed to learn more;

MSP 8 *"Although I knew a bit about learning disabilities it made me realise that I needed to learn more about how to communicate with children who are LD"*

MSP 9 *"As I didn't know much about Jehovah's witnesses other than that they refuse blood transfusions I thought I would better check what I should do"*

MSP 13 *"I didn't know much about her (the patients') religion and I was aware that I needed to improve my knowledge"*

Lack of knowledge related to particular cultural practices impacted on participants' perceived self-confidence. The concept of confidence featured repeatedly across the directed reflections and was characterised by a feeling of 'Not being sure what to do' and this in turn generated feelings of helplessness and anxiety and even feeling 'stupid';

MSP 2 "*Although you cannot expect to know everything it did make me feel anxious about how I was caring for this patient*"

MSP 3 *"I was 'on edge' but I can't really tell you why*"

MSP 4 *"I was quite anxious when I first discussed this with the patient"*

MSP 8 *"I felt a bit helpless really as I wasn't sure how much she understood and whether she talked or not and this made it difficult"*

MSP 9 *"I felt a bit stupid because she asked me to copy it and return it to her as I was just staring at it I think just deciding what to do for the best….Initially I was panicking as I thought that she might have to go down to theatre and that she would refuse a blood transfusion and that is quite dangerous"*

Interestingly, MSP 12 specifically referred to their own cultural competence,

MSP 12 "*some of the issues are outside my cultural competence*"

MSP's 9 and 10 specifically connected this deficit of knowledge to the novelty or uniqueness of the situation they had encountered as exemplified by the comments below;

MSP 9 *"I think you need to make sure that you know when someone is a Jehovah's Witness so you know what to do…if you know in advance then you can read the policy"*

MSP 10 "*I hadn't come across type of thing before and I wasn't very knowledgeable about the condition*"

Participants also viewed challenges as an opportunity to learn to develop;

MSP 3 *"it's good for me to be outside my comfort zone from time to time, as my care skills get really tested in such situations"*

MSP 10 "*I realised I needed to find out more about this condition and I made a note to remind me to look it up later so that I would be better prepared next time*"

MSP 14 "*Although I found the situation difficult it showed me that I needed to learn more and keep learning until I got it right"*

Some of the participants who indicated that they lacked confidence had acknowledged their limitations and went onto describe their approach to managing this. This was characterised by seeking more information or advice from others including senior colleagues;

MSP 1 *"When I finished I went and spoke to the senior nurse. She said she would speak to the family in private".*

MSP 6 *"I sought the advice of a colleague"*

MSP 8 “*I went and told the senior nurse about her”*

MSP 11 “*One of the nurses I worked with is Lithuanian so I went and asked her for some advice*”

Whilst the nature of the advice given by colleagues was not always described by participants in the directed reflections, for MSP 2, 9 and 14 the important element appeared to be that this request for help was responded to positively;

MSP 2 “*I did discuss this with my preceptor and she directed me to some helpful resources*”

MSP 9 *“once I have spoken to the ward sister I felt better as she told me not to panic”*

MSP 14 *“The discussion I had with one of the other nurses helped me understand the situation better. She offered to help me next time so that I could observe how she did it”*

Barriers to developing competence, skills or confidence were not explicitly asked for on the directed reflections. However, three of the participants (MSP 2, 6 and 10) referred to time and resource related pressures;

MSP 2 “*It is a really busy unit and we are often short staffed*”

MSP 6 “*If it has been a difficult day then I think you need to debrief after difficult encounters with patients but it is so busy most days that you don’t always get time to do it properly*”

MSP 10 “*I did follow up with this in my own time. Ideally it would be good if there was time for learning on ward but generally there isn’t because we are constantly on the go. So you do have to do it in your own time*”

For one participant (MSP 4) this had resulted in them feeling stressed during a difficult encounter with a patient;

MSP 4 *“I was a bit stressed as I realised that we wouldn’t be able to sort it out just then as we were in the middle of clinic”*

For another (MSP 9) this impacted on their opportunity for further learning;

MSP 9 “*I wish I had asked to go with X (name removed) to see what she said to the patient but I had to go sort another admission*”

6.2.3 Conclusion to the first transition period

In conclusion, for NQNs during the first three months of practice a number of different factors appear relevant to understanding CCPB. First; that

competence and confidence caring for patients from diverse backgrounds was interrelated. This mediated by a number of different factors including whether this was a novel experience or not and whether support and advice was available from senior colleagues and, or other members of the multi-disciplinary team (MDT). Second; their perceptions of the behaviours and actions that constituted CCPB were generally characterised by generic descriptions of behaviour that can be seen as reflective of core nursing competencies and considered relevant to all patients irrespective of their background. These included the importance of communication, practising with compassion, respecting individual differences and being professional. Examples of their behaviour were also given that were specifically in response to what participants saw as a diversity characteristic of the patient.

6.3 The second transition period

The directed reflections provided during 5 to 6 months post qualification contained some similar accounts of what participants' perceived to be CCPB at 2-3 months. They associated CCPB with generic nursing concepts and practice (e.g. person centred care, individualised patient care, practicing with compassion, respecting individual differences) and diversity specific behaviours or actions linked to a perceived patient characteristic. In this stage, there were also examples of participants being proactive in terms of caring for patients from diverse backgrounds e.g. in terms of pre-planning care prior to care delivery. Communication again featured as a key competency.

Participant perceptions' of their own competence and confidence however was substantially different at this stage to the previous one. They were more positive in outlook and this applied to their nursing practice generally as well as specifically in relation to patients from diverse backgrounds. There were no examples provided by participants of the stress, anxiety and fear that proliferated in the previous stage. On the whole they were no longer describing experiences that could be described as novel or unique to them although these experiences could still be challenging. Participants were also more focused on the patient perspective and showed more awareness of wide organisational issues and context.

6.3.1 Perceptions of culturally competent practice behaviour

When the nurses talked about their experiences of caring for diverse patients the focus was on describing CCPB as primarily delivering individualised patient care and respecting patients as individuals;

MSP 3 "*We talk a lot about 'putting patients first' but I think we just need to treat people with dignity and respect. As individuals*"

MSP 4 "*For me it is important that I feel that I have done my job correctly and with compassion*"

MSP 6 "*Treating people with dignity should be every nurses' priority. It is fundamental to good recovery focused care and demonstrates your respect for the patient and who they are*"

MSP 12 "*as a health professional I work hard at building trust and conveying compassion and to understand their (the patient) perspective and experiences*"

MSP 14 "*I treat everyone as an individual first and foremost. That's the starting point for good quality care – it's individualised and designed to meet their needs*"

Related to this was the idea of treating people 'the same as everyone else' as illustrated by MSP 2, 5, 9, and 13.

MSP 2 "*Everyone needs to get the same quality of care and treatment and so you need to treat people the same*"

MSP 5 "*I try to treat everyone with the same level of care and respect. People don't want to be treated as different*"

MSP 9 *"In terms of him being gay I don't think I did anything that was different to what I would usually do for a patient who'd had this op. I just cared for him as I usually would for anyone*"

MSP 13 "*I treated this patient the same way that I would treat anyone else who was admitted here*"

However, participants also reported that respecting patients' individual needs required them to treat someone differently to provide appropriate care;

MSP 4 "*I let the consultant know that she was wearing burka so that he could be sensitive to this during the consultation in case he needed to examine her*"

MSP 10 "*I explained that we would be doing some additional tests but that we did this routinely for people who were from Afro-Caribbean backgrounds because of the high risk*"

Assumptions about particular groups of patients were however evident;

MSP 2 "*The X (name removed) estate is overrun with drugs and we've had a few of them in here with problems and so I just bear that in mind when they come in just in case"*

MSP 4 “*I always check with the patient as some of our Muslim patients have poor English – and I wanted to make sure that she was not uncomfortable with what I was doing*”

MSP 14 “*They usually prefer to eat their own food*”

MSP 3 and 12 were aware of their own assumptions;

MSP 3 “*I also assumed elderly, plus stroke plus amputee meant completely dependent*”

MSP 12 “*When people access the service it is easy to make assumptions about them, their backgrounds. You have to be really mindful of that because their behaviour might be culturally appropriate for their community and background. This might be a perfectly legitimate expression of distress*”.

Respecting people’s individual needs and responding to their diversity was perceived as being an important part of nursing care and fundamental to the nurse-patient relationship;

MSP 1: “*It’s such an important part of nursing care. For the patient it is important because they feel like you understand them or are trying to*

understand them as best you can. That gives them confidence in you as a nurse and helps them feel cared for"

MSP 4 "*It's important that you are sensitive to people and their particular customs and practices in relation to religion…. it shows that you are being respectful and make the patient feel more relaxed and able to trust you*"

MSP 6 "*It is important to acknowledge people's difference and individuality. It says to them 'I know you are a unique individual'. Respecting their diversity is respecting them. Without this you cannot establishing a truly therapeutic relationship*"

MSP 11 "*I make sure that I respect people's religions, backgrounds, sexuality etc. when I am providing care as this is central to building a relationship with your patient"*.

In addition, participants gave examples in which they built on their previous experience and pre-planned care delivery, 'preparing for' rather than 'responding to' patient diversity. This was not evident in the directed reflections in the first transition period.

MSP 1 “*I had time to think about how I approached her and how best to ensure that she understood. If you can do this it makes it easier both for you as a nurse and the patient*”

MSP 4 “*I have done this a few times now and you work out how to do this with minimal disruption*”

MSP 7 “*I did a check of my previous notes before he arrived to make sure I was prepared for the session. I was able to access some resources and information in Kurdish ready to share with him*”

MSP 13 “*I got the information pack out ready before the admission so that I could share this with him and his family. I like to be prepared*”.

As in the first stage, communication feature as a core nursing competency and was relevant to delivering high quality care to patients from diverse backgrounds;

MSP 1 “*I think it is really important to communicate well to make sure people have the care they need and understand what is happening to them*”

MSP 7 “*When your patients do not have English as a first language you have to invest extra time and effort into communicating. You cannot assume a shared understanding and this has to be explored constantly throughout the session”*

MSP 10 *“You have to make sure that you are communicating effectively with all your patients. If they are from a non-English background and perhaps their English isn’t very good or they have communication difficulties then you as the nurse are responsible to make sure that communication is appropriate to their needs”*

MSP 12 “*It was important that I used my skills to work with the patient to establish trust and a respectful way of communicating*. *The young man arrived at the session agitated and stated clearly that he did not wish to be in the session. It was important that I communicated effectively with him to explain the purpose of the session and listen to his concerns and anxieties”*

Participants continued to speak about the challenges they faced when communicating. These were related to language barriers (MSP 1, 7), the impact of a clinical condition on a patients’ communication (MSP 3, 10) and a patient who used offensive language (MSP 12);

MSP 1 "*She spoke some English, she was quite difficult to understand at times*"

MSP 7 "*As he did not have English as a first language, there were some language barriers initially and this did cause us some difficulties*"

MSP 3 "*he got very cross and a bit aggressive and upset with me and because his speech was a bit slurred I couldn't fully understand what he was saying"*

MSP 10 "*She became disorientated and this made communication difficult as she did not appear to be able to understand what I was asking her to do".*

MSP 12: "*It was difficult for me at times as the language he used was quite offensive (swearing) and also he challenged me by stating that I didn't know what I was doing and that I was 'a waste of space'*"

There were however, examples of enhanced skills in communication and using verbal and non-verbal skills to overcome some of these challenges;

MSP 3 “*I rephrased what I was saying I was careful to keep eye contact with him and keep checking with him both verbally and non-verbally whether I was doing it right*”

MSP 7 “*I was able to access some resources and information in Kurdish ready to share with him”*

MSP 9 “*I tried to speak simply (no jargon) and clearly – I also would ask her whether she understood what I was saying to her. When she was speaking to me – I asked her to speak slowly too so that I could understand her (she had quite a strong accent).”*

MSP 12 *“I was able to use both verbal and non-verbal communication methods to reassure him and de-escalate the situation. I spoke quietly and calmly, explaining what was going to happen and listened carefully to what he said. I used my body language (posture) and facial expressions to communicate warmth and encouragement*”

MSP 13 “*I just held his hand for a while so that he knew I was there*”

Participants recognised the impact of communication on the patient experience, trust and confidence in the nurses' competence and professionalism;

MSP 1 *"I was aware that she might have some difficulty with communicating with the nurses and HCA's in terms of expressing her needs as well as understanding what was happening in terms of her care. It is important to me that I get communication right with patients as I want to be the best nurse I can"*

MSP 3 *"It is also important to make sure that when you are feeling impatient or cross with the patient try not to show and remembering that it's not their fault"*

MSP 12 "*I role modelled good communication to the patient acknowledging his anger and anxiety and providing a supportive environment in which he could express himself without being judged*"

MSP 14 "*Although communication could be difficult at times I spent extra time with her to ensure she fully understood what was going to happen. Patients need to fully understand the procedures before they agree otherwise you are not getting informed consent*".

Communication challenges were also framed differently to those provided during the first stage. Communication was generally described as a problem or challenge that was the nurses' responsibility to address rather than this being a problem or challenge located with the patient.

MSP 5: "*If a patient has communication difficulties then it is the nurses' responsibility to support them to express themselves or to find ways to assist them in communicating*"

MSP 7: "*You have an obligation as a qualified nurse to communicate in a way that your patient understands*"

MSP 12 "*Without trust and respect between client and practitioner, therapeutic goals cannot be realised and the client is further disempowered and excluded. It is the nurses' responsibility to ensure that this is achieved*"

Although there were exceptions to this, for example, MSP 3

MSP 3 "*It would have been a bit more straightforward if he could communicate better*"

6.3.2 Self perceived competence and confidence

In contrast to the first transition period, participants described situations that were no longer 'novel' to them;

MSP 2 "*We carry out this procedure almost every day*"

MSP 6 "*We often get patients referred into the service with similar issues*"

MSP 12 "*I have worked with many patients before who arrive at a session quite agitated*"

MSP 14 "*I have had a lot of experience caring for patients undergoing this particular investigation*"

And MSP 1 and 10 acknowledged how they had previously felt dealing with patients in such situations;

MSP 1 "*I used to be anxious that I wouldn't get this right and perhaps increase a patients' distress*"

MSP 10 “*I used to find caring for patients like this difficult but I am more experienced now*”

They also reflected on what they might have done differently to respond to a particular patient or situation;

MSP 3 “*I realise I was probably wanting to get this done quickly rather than give him time to do this with minimal support and maintain his independence*”

MSP 9 *“I could have asked him personally whether this was what he wanted”*

MSP 14 “*In retrospect I should have spoken with the family beforehand as this might have helped*”

MSP 3 and 10 also provided examples that illustrated how they had reflected during an interaction with patients 'in the moment' and were able to change their practice in response to this;

MSP 3 “*By talking to him and finding out his concerns I was able to (I think) reassure him and also tell him what he could do - I realised I should have spoken to him earlier*”

MSP 10 “*I wasn’t sure that she fully understood everything so later I went back to her and asked if she wanted me to go through it again with a member of her family. She said yes her daughter so I also explained it all to the daughter”.*

Finally, in this stage there were descriptions of practice that illustrated their emerging professional identity and participants referred to themselves using the term 'We' (as in the MDT) rather than 'I' (the nurse).

MSP 1 “*we all work hard here to make sure that we are good communicators*”

MSP 5 “*We tried to make sure that we meet the patients’ needs and he did not feel excluded in any way*”

MSP 7 “*We made sure that the client was referred to the relevant services*”

MSP 13 “*When he was discharged we felt that we had provided culturally appropriate care for him and his family*”

MSP 14 “*We worked as a team to care for this lady*”

In addition, there were examples of pride in the profession of nursing and recognition of the importance of these experiences to their personal and professional development;

MSP 1 "*I enjoyed caring and learning from this patient as it helped me expand my knowledge as a nurse*".

MSP 3 "*The good thing about being a nurse is that you are always learning new things and new and better ways of caring for people. Patients make the best teachers*"

MSP 6 "*By caring for this patient I am better informed and understand more about what it means to experience discrimination and stigma because of your sexuality*"

MSP 14 "*Situations such as this are useful to reflect upon so that you can learn from them and develop your practice*"

6.3.3 Awareness of wider organisational context and constraints

Participants were not asked specifically about barriers or enablers to their practice in the directed reflection at this stage, but they did describe time and resource related pressures;

MSP 3 "*you don't always have the time to do things exactly how you would like I try to approach every patient with care and compassion sometimes you get overwhelmed with the amount of stuff you have to get through on an average shift… you kind of just rush off to do something and you are already thinking about the next thing you have to do even before you have started this one*".

MSP 7 "*Although I am confident that I was able to meet this clients' needs on this occasion I am aware that due to staffing issues I do not always have the time to pre prepare as I did in this case scenario*"

MSP 10 "*It is a very busy unit and it can be very stressful. I always try to make time to talk to families if I can but sometimes I just run out of time"*.

In a busy environment, participants were required to prioritise the immediate clinical situation;

MSP 8 "*At first my main concern was the girl, making sure she was ok and pain free – the needs and the wishes of the father came second place to me in those circumstances*"

MSP 14 "*I focused on the obs first as I wanted to ensure that she was clinically stable before I did anything else. Then I called her family*"

In addition, the wider environmental context had played a role in the reflection provided by MSP 9;

MSP 9 "*I didn't mind them holding hands or kissing but I thought the other patients might be a bit funny about it. I didn't want the other patients to feel uncomfortable or him or his partner…..I think you have to think about all the patients in the ward area (when it's a six bedded bay) I had to think about the other patients too"*

No participants provided an example of how they sought out the support or advice of senior colleagues. This is in direct contrast to the examples provided in the first stage.

6.3.3 Conclusion to the second transition period

CCPB was perceived by participants as fundamentally linked to core nursing concepts. Individualised patient care, compassionate and respectful care, understanding and respecting individual differences; were all considered essential to establishing the nurse-patient relationship, engendering trust and underpinned by positive communication approaches. CCPB was thus seen as both competent and professional nursing care and an important element of the nurses' professionalism. Whilst some examples were provided of how participants responded to a particular diversity characteristic of the patient these were in the minority in comparison to the previous transition stage. The majority of examples given made reference to generic nursing competencies.

Participants were also less focused on themselves; their own perceived competence and confidence and more focused on the patient experience and perspective within the caring encounter. This more outward looking perspective was seen in the change in focus in terms of the language they used (less 'I' more 'they'). In addition, in their descriptions of communication challenges they were more likely to see this as something the nurse needed to address rather than a problem experienced by the patient. They were also more example of participants referring to 'we' (as in the nursing team or MDT) rather than 'I' (the individual nurse). Participants had reflected on their interactions with patients and had considered their own assumptions.

6.4 The third transition period

In the final transition period (between 8 and 9 months since commencing employment) interviews were conducted with participants. Participants' perceptions of CCPB continued to be linked to generic nursing concepts and practice. Descriptions of specific actions or behaviours they undertook in relation to a patients' (perceived) diversity characteristic was illustrated by examples in which they used their professional judgement and prepared for rather than responded to perceived patient needs. A new perspective that emerged at this stage was CCPB as potential and actual complexity within the caring environment. Communication again featured as a key competency and this continued to be perceived as a shared challenge between nurse and patient and essential for communicating with others (families, colleagues, the MDT).

Participants also reflected on the transition period and the directed reflections they had provided, describing how they had changed ('me then' and 'me now'). Throughout these reflections on their former selves, participants described how they had learnt from experiences caring for and interacting with patients from diverse backgrounds. Participants perceived themselves as competent and confident and this was in direct comparison to their earlier perceptions. They were motivated to develop and improve their practice by a pride in the profession of nursing, a desire to be 'a good nurse' and to earn the respect, trust and confidence of their patients and colleagues.

Personal and organisational enablers and constraints to their development were highlighted including the impact of time constraints and workload pressures and the impact of 'others' (other patients, families and carers, the environment). Specific reference was made to the importance of positive workplace culture (team working, leadership) on their practice and the relevance of their own personal diversity and experiences on patient care.

6.4.1 Perceptions of culturally competent practice behaviours

In this final stage, participant perceptions of CCPB remained focused on the importance of individualised patient care and respecting people as individuals;

MSP 2 "*I think you need to focus on the individual the person who they are and what they need - their background, religion or culture is part of who they are*"

MSP 6 "*For me it's linked to person centred care, it's all about the individual person not patient or client or customer. They are a person and that is what you have to focus on*"

MSP 8 "*being nursed by someone who is sensitive to you and kind of understands your background and life kind of thing – well that's better for you*

as a patient isn't it. That's what I think (pause). It's all about delivering individualised care"

MSP 11 "*When they come through the door they don't stop being individuals, that's why the best care is individualised patient care*"

Understanding and responding to the diversity needs and, or cultural characteristics of the patient was perceived by participants as important for delivering competent and professional care;

MSP 1 "It's like 'You will provide the very best care for patients and their families' and that's for everyone not matter what their background is, who they are, where they are from. It's the standard that was set on day one and that's what we expect of each other".

MSP 4 "*so it does have to be culturally sensitive because that's important to them so yeah I just mean it just needs to, it just needs to be that sort of care, the sort of care that they expect to receive really, that they hope to receive (pause)*"

MSP 8 "*It doesn't matter where they are from or what their background is really. At the end of the day I am here to look after them, that's my job*".

MSP 9 “*I think you also have to be knowledgeable about lots of different things, different cultures and things like that because that might be important*”

MSP 4 and 11 associated this with the concept of caring;

MSP 4 **“***yes I do think nurses need to be sensitive to people’s religions and things like that well because that’s what caring is about really….If it’s important to them then it should be important to you”*

MSP 11 “*I am not sure I always understand what people mean by culturally competent care but for me it’s fundamentally about caring; that is what nurses do, they care about people, they provide care*”

Specific actions or behaviours undertaken in response to the patients’ (perceived) diversity characteristic involved ‘asking patients’;

MSP 1 “*If they have a particular religion then we understand that when it comes to end of life care then they will want to see a priest or vicar or Iman. We ask them and we ask the family. Religious needs and well spiritual needs as well they are taken very seriously here. They are important to our patients, sometimes even people who aren’t religious may want to see someone so you need to ask don’t you*”

MSP 9 “*We ask whether they need a special diet or something, maybe to use the prayer room or some special equipment or bed*”

For MSP's 6 and 11; asking patients was linked to assessing and planning care, preparing for rather than responding to the needs of;

MSP 6: "*Well you need to ask them don't you, or their family or carers that's part of the assessment process – asking those questions and finding out how you are going to care for them… it's part of the care planning process*"

MSP 11: "*Sometimes there are things that you can do like making sure that they have the right sort of food but I think it's much more complex than that and it comes back to how you assess your patients. That is crucial to knowing what they might need and then you can plan the care*"

MSP 13 "*If you know a child is being admitted that is from a particular religion or has a particular language then we have information leaflets and things we can share. But I think it all comes down to that first meeting between you, the child and the family. That's when you ask the questions about what they need and what matters. Then you can prepare a care plan to reflect what they tell you"*

Communication was continually reported as the core to the skills of CCPB;

MSP 1: "*It's such an important skill and you really need to be a good communicator not just with patients and their families but also with colleagues too. Communication really is the key for me; it's that first building block in your relationship with your patien*t".

MSP 3 "*I think I would say communication is the main skill….and that's communication in the broadest sense if you know what I mean, verbal and non-verbal because even if you don't speak the same language as someone you can still communicate with them, show them that you are interested, that you care and that they matter*".

MSP 4 "*I mean communication is probably the main one…I think I probably do that with all my patients you know, keep checking with them just to make sure they are ok. I mean I tell them what I'm going to do you know and then just ask you know 'is that ok' (pause). It's about communicating with the patient and them back with you*"

MSP 8 "*Also how you communicate with them, because that's really important. You need to be able to communicate well with your patients so that you can properly assess their needs and then explain to them what is happening, what's going to happen as much as you can really. You need to be able to get your patients to trust you, to tell you things*"

MSP 9 “*Communication – it really is the most important thing you do every day with everyone*”.

MSP 14 *“I think it’s about good communication with your patients. Whether they speak the same language as you are not. You still need to care for them and communicate with them”*

In addition, providing culturally appropriate care required effective communication with others (families, colleagues, the MDT);

MSP 2 “*it’s not enough just to be good at communicating with your patients you really have to be able to be a good communicator with everyone so that people know what is going on*”

MSP 4 **“***you just get into the habit of telling each other what’s going on, give people a heads up really if there is something they need to know. Like I said before it’s all about communication, you need to get it right with the patient but also with your colleagues. That’s how you make it work well in the clinic. Team working really*”

MSP 8 “*once I had spoken to him and got a feel for what was going on it was important that everyone knew what was going on you see*”.

MSP 9 “*you have to be a good communicator and I think that is something I have really picked up on working here yes*”

MSP 12 “*Regular team meetings and debriefings are important to keep the whole team informed communication is an important function of any team. But also for us it’s an opportunity to reflect upon and share our experiences and challenges with our peers and seek feedback and support”*

MSP 13 “*We make sure that we keep communicating with each other too so that no-one is left out of the loop*”

When asked to describe CCPB’s, some participants referred to other attributes;

MSP 2 “*You really need to know a lot about different people’s cultures, their religions and backgrounds and embrace that, take it on board because it’s part of who they are. Is that a skill? Maybe because it’s not just about knowledge is it, you have to do something with it, make it part of how you nurse. Is it a skill? I think so*”

MSP 6 “*The skills? …. is about how you interact with your clients and how you practice in a non-judgemental culturally-aware way. It’s not one skill but*

there are many and I would say that it's about attitude too. And self-awareness"

MSP 8 "*being open and honest is important too. So it's kind of having that kind of attitude to people so that they can see that you are accepting of them, you know, that you are prepared to listen, hear what they are saying*".

MSP 10 "*maybe the skill is in that interaction with the patient but really I think you have to sensitive to someone's needs*"

MSP 11 "*I think it's about how you apply the information you get from your patients and it's about clinical judgement because sometimes a persons' ethnicity or religion is relevant to the surgery they are having. It might not be relevant if you are just taking their temperature but if you are taking blood it might. There's are a lot of sensitivities we need to take into account when planning their care and I think the major skill is knowing when it is relevant*"

Two participant responses stood out from the others when asked to describe CCPB - MSP 5 and 14;

MSP 5 "*Well it's hard to say really, who knows what it means. I mean I remember learning about cultural competence and all that and even at the time I just thought well isn't that just nursing, isn't that just being a skilled*

nurse. These skills, these are nursing skills. I don't know why you have to say culturally competent nursing skills"

MSP 14 *"I am not sure I really understand really what people mean by cultural competence anyway so it's a bit difficult to say. When people talk about it they usually mean black and Asian and minority people and that kind of thing but really everyone has a culture don't they?* "

Participants still described challenges communicating when there was no shared language proficiency;

MSP 1 "*but at first well we struggled, both of us just trying to understand each other. She had this really strong accent so even through her English was ok it was hard sometimes to understand what she was saying and well you know well all of us struggled to understand her.*"

MPS 2 "*There is still the odd day and you think oh no I am not sure how I deal with this one but generally you just give it a try and see if it's going to work or not*"

MSP 6 "*When someone is distressed they can often find it difficult to express themselves and when you are trying to do this in another language well you*

can see how difficult that must be for him. I think the fact that I tried and kept trying was important, it was important to the client-therapist relationship"

MSP 8 "*it's difficult sometimes because when children are admitted well they don't respond to you for lots of different reasons*"

MSP 10 "*When your patient speaks a different language to you of course it's going to be a bit of a problem and the important thing for me is recognising this early on so that you can find a way to help that*".

MSP 14 "*I think the language barriers can be difficult yes but they don't stop you communicating really do they, they just make it a little more of a challenge!"*

For MSP 10, language barriers existed between colleagues too;

MSP 10 "*But it's not just patients is it. We have staff whose English isn't great either and sometimes it's hard to understand what they are saying. That can be hard for patients too and sometimes they will ask me to tell them again because they didn't understand when Dr so and so told them*".

However participants also described how their communication skills had developed since they had commenced employment;

MSP1 "*I think one of the things working here is that you become really good at reading the signs when people are in pain, the non-verbals because we have so many patients you know who might not communicate well so like if they have dementia or sometimes people are just distressed and in pain and they cannot speak with it so you get good at watching people*"

MSP 2 "(Communication) *it one of those things that keeps developing the longer you are in the job. And I think now really I use a lot more non-verbal ways particularly in that postop period. They really don't want you yakking away and talking at them so I keep it simple, reassuring them, smiling, squeeze their hands. You know that sort of thing"*.

MSP 10 "*At first I think I had to think about it y'know, how I would tackle it if there was a problem or they didn't speak English but I am so much better at it (communication) now. It becomes second nature to you and I will access the interpretation services if I think we can't manage or we can use their families. But we also just have lots of information in different languages and alternative formats so I can just print one out if I need it"*

For MSP 9 and 13 their communication skills had developed because of the diversity of the patients they had interacted with;

MSP 9 "*So one minute you are talking to an Asian man with the help of his wife or kids and the next it's an old lady with a hearing aid that doesn't work*".

MSP 13 "*We have so many kids here speaking different languages and some have great English and some don't but I am used to that and I kind of like it you know the constant chatter in different languages. And you pick the odd word here and there*"

Finally, CCPB was also linked by some participants with the idea of diversity adding complexity to 'usual care';

MSP 3 "*You see it differently after a while yes more experience is important in dealing with it and the Muslim thing – well that was just added a layer to the situation.*"

MSP 4 "*I think with this one the language issue for me kinda just got in the way and made things a bit more complicated*"

MSP 5 “*I am probably not explaining it right but it sometimes feels like when you get a patient in and they have complex needs – well things aren't so straightforward you have to think a bit more about their care and how you deliver it don't you. And for me when someone says they are Muslim or Hindi or whatever well I have to think about that a bit more and what that means and well it puts extra pressure on us. It's something else we have to do, it's not so straightforward if that makes sense*”

MSP 11 “*We try to accommodate people as much as we can really, of course we all want everything today to be easy and straightforward and when someone suddenly wants something different well people get a bit uptight don't they. It's not care as usual and the usual routine might have to change a bit. I think when people are under a lot of pressure having to deal with something a bit different well it just makes it a little more complicated for them*”

6.4.2 Reflecting on transition

When discussing their directed reflections produced earlier in their transition, participants reflected on their former selves and how they had changed both personally and professionally;

MSP 1 “*I think I probably was a bit of timid thing when I started here, first proper job and all that suddenly you are out on your own and well you know it*

was great but still it's a huge leap from being a student ….. I feel like I know what I am doing and I'm not trying to prove myself you know"

MSP 4 "*so you get better at it, better at being a nurse really, better at dealing with patients', better at understanding them and what they need. You learn a lot especially in those first few months (pause). I think I have improved a lot over the last 6 or 7 months certainly and I am more confident now then I was to start with but you do get more confident don't you"*

MSP 5 "*it's massively different to being a student and although I felt I was ready there was so much to take in*"

MSP 7 "*I think I was fairly confident when I started really and I wanted the challenge of working in this service but I have learnt so much here. About patients, about myself and I hope I just keep learning*"

MSP 9 "*But I have been here for quite a while now so I am pretty familiar with how things are done and now some of the newly qualified staff ask me*".

MSP 10 "*I was a complete rabbit in headlights. I really wanted to do well and impress people but was terrified of messing up. But I did it. I got my head*

down and I worked hard and I tried to learn as much as I could as quickly as I could"

MSP 13 "*I can hardly remember that person and it was only about 8 months ago*"

Participants were reflected on what they had learnt caring for patients from diverse backgrounds. For some, this was related to knowing more about particular groups of patients (MSP's 1, 3 and 9) and for others it was more general learning (MSP's 1, 4, 6, 7,11);

MSP 1 "*I have learnt a lot about different people's approaches to death and dying and how, depending on their religion what you need to do. We make sure with the patient and the family we know exactly what they want*".

MSP 3: "*I really didn't know much about his religion you know with him being Muslim and how that effected what I did…I have looked after quite a few more Muslim patients now so am better prepared although sometimes I think I still don't really get it always right but you kind of learn as you go along in this job (small laugh - Pause). Also now I kind of understand a little more why that was difficult for him*"

MSP 9 "*I realised that it's not always straightforward you know because they might say that there are ok about it but they won't want the rest of the family to know because you know well that wouldn't be viewed well. So it does depends on them and what they are ok with I guess*"

MSP 1: "*I did used to get a bit nervous when a patient would come in and you know well they had complex needs and I would be flapping a bit thinking can I do this? but you realise you can that's what you are trained for after all*"

MSP 4 "*I think I definitely know a lot more then when I started you know about different people, different conditions and things like that".*

MSP 6 "*You learn from all your clients, every one, every day. They are from all different backgrounds, different ethnicities, sexualities, abilities …. You learn from them all*"

MSP 7 "*I think you learn the most from those experiences that most challenge you, the ones that make you think. People from diverse backgrounds often challenge me but in a good way, they challenge me to use my skills and to improve*"

MSP 11 “*I have certainly learnt a lot from all the different patients that come in here. It’s what makes nursing so interesting every day is different*”

Participants were discussed further development and CCPB as illustrated by MSP’s 3, 4, 6, 7, 9 and 12;

MSP 3 **“***I have done some reading to help me understand how better to communicate with dementia patients as we get quite a lot of them here*”

MSP 4 “*I think just improving on the ones I have already you can always improve and get better at what you do*”

MSP 6 “*there are always new skills to learn I think, new ways of doing things. Learning and developing to part of being a nurse and if you are not doing that then I would question what you are doing*”

MSP 7 “*I am committed to my continued personal and professional development and have already enrolled on a course starting next year to develop my practice*”

MSP 9 “*I do know a bit more about it now because after that I made sure I learnt about it you know read the policy*”

MSP 12 “*shared learning happens as part of the therapeutic process. Yes I continue to learn and develop as a nurse, as a therapist and as a person*”.

Two participants felt that they were now sufficiently skilled to deliver care to patients from diverse backgrounds;

MSP 5 “*I think I am probably in a good place now and I do think I have the skills to deliver care to any patient who comes through the door. I am not saying I know everything but if there is something I don’t know I make sure I find out*”

MSP 11 “*I am doing well here and am already one of the more senior nurses on the unit. I do feel confident about what I do and I think I am good at it*“

Participants also described their desire and motivation to continue to improve and to be perceived as ‘a good nurse’;

MSP1: “*I wanted to be a good communicator and do the best job I can for my patients*”

MSP 5 “*I have always tried to find out things, get more information and that if I wasn’t sure. I want to be a really good nurse…it’s all I ever wanted to do and I want to do a good job. That’s what keeps me going really, just that. I want to be the best nurse I can”*

MSP 7 “*I am hoping that this course will make a difference to my patients….make a difference to me too because well I want to keep learning and improving. I think I am a good nurse but I also think I can be better*”

MSP 10 “*It isn’t easy keeping on top of it all but I keep at it, keep looking for new information, evidence and things like that. As I said before I want to do well in this job, I want to go home knowing that I’ve done a good job, that I am a good nurse”*

MSP 11 “*I want people to think that I am competent, a competent nurse who they can rely on”*

MSP 13 “*I don’t think people choose this job because it’s easy … they choose it because they want to be nurses, they want to care for people and they want to do a good job for their patients. And that matters y’know, even if you don’t always have the best of days, that motivation well that’s what keeps you going, keeps me going anyway”*

MSP 14 "*Simple really I just want to be a really good nurse … the one that patients remember*"

6.4.3 Reflecting on personal and organisational enablers and constraints

During the interviews participants talked about the challenges in the clinical environments in which they worked; these were primarily related to time constraints and workload pressures;

MSP 3 "*It's just time and workload and too many patients and not enough staff well that's the things that do affect you, do affect what you can do and how you do it really"*

MSP 4 "*I know it's difficult at times, its busy, it's always busy*"

MSP 8 "*too much work not enough staff. Most days you are running around trying to get everything done and trying to make sure your patients have everything they need*"

MSP 9: "*It's always busy and yeah sometimes people get stressed, things don't always good according to plan but that is how it goes sometimes*"

MSP 10 "*it's a busy unit and the work is non-stop, you are lucky if you get a break sometimes*"

MSP 14 "*it can be really stressful at times there is just so much to do, so much I don't know how we get through it most days. I am absolutely dead on my feet at the end of a shift, really k******red and just want to crawl into bed. Then you are up and it's the next day and here we go again"*

MSP 11 however had a slightly different experience;

MSP 11 "*Yes we have our busy days, like op days, they generally are busy but we make sure we have plenty of staff in on those days. And if it looks like we need more well we can ring round and staff will come in mid shift if we need it*"

An area that emerged during transition stage two was further explored in the interviews and that was the impact of others' (patients, families, carers) behaviour on the nurses' experience; MSP 1, 5, 9 and 12 recalled challenging experiences;

MSP 1: "*Erm yes well it was a bit difficult at the time you know, I mean her family were a bit much but it wasn't her fault y'know but you just have to get on with it (pause)…. just saying stupid stuff about me like whether I had been in the country long and all that and whether I understood them. I think he thought he was being funny (pause). A lot of the time just under the breath or as I walked away so I only half heard but it started to really wind me up y' know. And then he said well I don't like to use the word but he called me a P*** and I just thought well this is it you have crossed the line now*"

MSP 5 "*Sometimes well, it's the patients, there are patients that can be difficult you know, rude and that. Just really unpleasant and it's not nice how some people think they can speak to you. But you just have to walk away for a moment*"

MSP 9 "*even though well you don't agree with them and thinking they are like a bit homophobic and that they should just keep their opinions to themselves they are still your patients too. With them being a gay couple and everything we have had some issues before with patients being uncomfortable and everything. There was one in particular who was awful and he kicked off about it and was really quite offensive*".

MSP 11 "*The patients we have in here, well sometimes they can be a bit much, it's hard to explain but sometimes they treat you are some sort of personal slave*"

MSP 13 "*I find it hard sometimes with the parents, with the kids' families. They can be a real handful, really aggressive with you at times and it is upsetting, you do get upset and sometimes you think 'you really aren't helping the situation here'*"

Participants also described the impact of their own personal diversity had on their experiences of care and how that impacted on care delivery; this was illustrated by MSP's 1, 4, 8, 9 and 13;

MSP 1: "*I do think that if you do have that kind of background it just makes you more sensitive and aware of diversity, erm maybe more aware of the potential for people to be discriminated against you know in healthcare and that kind of thing. So I think you maybe are a bit more open to that as a person because it's you isn't it, you and your family who can be discriminated against*"

MSP 4 "*I think the fact that I am a little bit older has helped me a bit really, I mean I have had more life experiences and I've worked before so I think that gives you something, something extra so you understand maybe a little more about life"*

MSP 4 went onto explain their views on personal diversity and patient care;

MSP 4 "*just because you are from one type of background, I don't think that means you can't look after, er be a good nurse for someone who is from a different background*"

MSP 8 "*I come from a right mixed up background, Asian, British, a bit of welsh in there, my sister married a Greek guy so that added a whole different*

culture into the mix - Having that kind of background is important I guess makes you a bit more accepting than maybe others".

MSP 9 "*When you have grown up with that and you see what it can be like for people it breaks your heart and yes it definitely makes you more aware of just what things can be like for people, I mean I'm not gay so I don't have that experience but with my brother and his boyfriends and their friends I have learnt a lot and I do think it's made me a better nurse*"

MSP 13 "*It does help I think, we get a lot of families, kids who are Asian and I get that they identify with me because I'm Asian too*"

For MSP 1 and 13 having a personal experience of diversity could also be a disadvantage when delivering care;

MSP 1: "*my ethnicity sometimes can be a barrier with patients or their families like we talked about earlier. They might have an issue and that makes it difficult for me to care for them because they are not comfortable being cared for by me. But that is rare I would say, really it is*".

MSP 13 "*I try not to take it personally but just some people are well you know maybe a little bit racist. Maybe that's harsh. I don't know really. But it's just a*

feeling you get from them, that they don't want you to look after them and they want one of the other nurses"

For both of these participants, they were concerned that this behaviour from patients would impact on the care they delivered;

MSP1 "*I was just concerned you know that I might treat her differently because of it because I was getting wound up even before I got near her bed if they were there. You know just expecting them to say something (pause*)"

MSP 13 had similar concerns to MSP 1;

MSP 13 "*Even though it's not me, it's them you do wonder 'I am avoiding them?' you know keeping out their way, just so you don't come into contact with them. I try not to but it's there at the back of my mind sometimes, that I am avoiding them. I don't want to but you can't help but feel like that sometimes"*

Although participants discussed some of the challenges they faced in practice, they spoke positively of their colleagues and how they felt accepted and part of a team;

MSP1 “*One of the things that I really like about working here it that the staff are all very committed… Everybody works together, helps each other and if you are struggling you get support. The workplace culture is very positive”*

MSP 4: “*you have to get on really to make it all run smoothly …. I have started socialising with them, going out and that kind of thing*”

MSP 5 “*it’s all about team working at the end of the day, you need to be able to work together otherwise you run into problems. They are a good lot here, nice people and they have been great to me since I started here, encouraging*”

MSP 8 “*but for me I think it’s been more than just being part of the team here you know, you learn a lot from them, from different people sort of every day and that’s the main thing*”

MSP 9 “*yes there are definitely some people here that have taught me a lot about patients, about how to care for them and how to do the job really I suppose*”.

MSP 10 “*it’s a great working environment here, and I think we work well as a team. When I first started here they really looked after me, until I found my feet and could get on with it. I feel part of this unit now, part of the team*”

For MSP's 1, 8 and 14, a key aspect of this was feeling supported;

MSP1: "*yes, X (name removed) was really helpful that day just well she could see I was upset and angry and well when I told her she totally got it you see. And it was great really because I probably wasn't in the right state to deal with it so she took it on and went to speak to them*"

MSP 8 "*if there is something about some religion you don't know then that's ok because people here are open here to that and you can ask and they tell you. So yeah there is a lot of that, sharing, giving advice*"

MSP 14 "*I've made some good friends since I started here, people who I really get on with, my friend X (name removed) left last month and I was gutted but she got another job and we are still friends though so that's fine*".

Only three participants specifically referred to challenges with colleagues (MSP's 4, 9 and 14).

MSP 4 "*there are definitely the one or two, you know the minority that are quite dismissive of other nationalities but on the whole definitely quite understanding and quite respectful*"

MSP 14 "*I would say they are a good lot, but if I am honest some of them I just don't get on with. I mean I work with them and that it but I wouldn't be friends with them because they can be a bit b***** and I don't like that*"

For MSP 9 this related specifically to their designated preceptor;

MSP 9 *"(She) didn't really have that much time for me. I think maybe I had been dumped on her and she didn't want to do it. Maybe she didn't like me I don't really know but it was a bit rough on me when I first started and she was like I can't be bothered*"

The support of another colleague however did prevent this NQN leaving the profession;

MSP 9 "*If it wasn't for X (name removed) I probably would have left myself but I was on lots of shifts with her so that she helped me out*"

6.4.3 Conclusion to the third transition period

In the final transition period participants' perceptions of CCPB were quite similar to those provided at the second transition point. They were predominantly linked to generic nursing concepts, values and behaviours and

informed by knowledge, awareness and previous experience. The participant's pre-planned care to meet the needs of diverse patients and communication again featured as a key competency. This was perceived as a shared challenge between nurse and patient and also essential for communicating with others (families, colleagues, the MDT). Unique to this stage in the transition was that some participants perceived CCPB as potential and actual complex care.

Participant described how they had learnt from experiences caring for and interacting with patients from diverse backgrounds as well as from peers and colleagues within workplace settings. They saw themselves as competent and confident, had a pride in the profession of nursing, a desire to be 'a good nurse' and wanted to earn the respect, trust and confidence of their patients and colleagues. Personal and organisational enablers and constraints to the development of CCPB included time constraints and workload pressures and the impact of 'others' (patients, families and carers, the environment). Specific reference was made to the importance of positive workplace culture (for example team working) on their developing practice. Participants considered that their own personal experiences of diversity could have a positive impact on patient care, however for two of the participants this resulted in negative encounters.

6.5 Data integration and synthesis

6.5.1 Introduction

The preceding sections have highlighted and discussed the key concepts, ideas and themes that emerged from each of the transition points in this study. The maps generated from each of the transition points are shown in Appendices 8-10. This represents the collective stories of the participants at each stage of the transition. In this final section of this chapter, the data is subject to a further re-examination with the purpose of integrating the parts into a 'whole data' story and explore persisting themes, connections and interrelationships.

Within this aim in mind, the integrated findings focus on CCPB and the relationship of this with the secondary construct; the NQN in Transition (NiT). These two key constructs are intimately interlinked with the latter informing the former and vice versa. Cross cutting themes and sub-themes were evident within each of these and participant perceptions of CCPB and skills varied at each of the transition points. Some themes become more prominent as the NQN developed and others diminished and, or changed focus. The primary and secondary constructs (CCPB and NiT) and their subthemes are described and the intersectionality of these are proposed.

6.5.2 Culturally Competent Practice Behaviour (CCPB)

CCPB across the transition period was perceived as comprising behaviours or actions that could be explained in generic terms (G: generic) i.e. they were

related to core nursing competencies and values. CCPB could also be described as specific actions and, or behaviours that the nurse undertook in response to the perceived diversity characteristic of a particular patient (DS: diversity specific). CCPB was comprised of (5) subthemes which were;

- practising with compassion
- respecting individual differences
- professional care
- patient trust
- managing complexity

Communication was identified as the primary skill or competency in CCPB and this was a cross-cutting theme or variable as communication was perceived as both DS or as G, or in some cases both.

6.5.2.1 Understanding CCPB as generic (G) and diversity specific (DS) nursing behaviours or actions

Perceptions of CCPB in the first stage were described in DS terms and included actions or behaviours. That is, participants described circumstances in which they felt that a patient needed to be treated differently because of a perceived diversity characteristic. The diversity characteristic was isolated from the patient and a specific action or behaviour was undertaken in response to that characteristic to meet the patients' (DS) needs. The examples provided by participants were dominated by communication and

were particularly focused on the challenges NQNs faced when caring for, or interacting with, patients from diverse backgrounds.

These challenges were predominantly DS and related language barriers, communication was seen as a ‘problem’ or ‘challenge’ to be addressed and this problem was perceived as located with the patient. That is, the patient had difficulties communicating with the nurse. Whilst some participants linked CCPB with generic nursing concepts such as respecting individual differences and professional care this was very much a minor theme in transition stage one.

By stage two, CCPB as behaviours and actions were described in more G terms rather than DS. CCPB as G became a more dominant theme and was increasingly described in terms such as practising with compassion, respecting individual differences and professionalism. Importantly CCPB was seen as underpinning the nurse-patient relationship, necessary for establishing patient trust and confidence and was linked to delivering quality patient care. Whilst participants continued to provide examples of CCPB as DS actions or behaviours these were less frequent and explicit. Respecting individual differences was a key (sub) theme of CCPB in this stage, however the focus changed. That is, instead of this being framed in terms of treating people differently (DS), the focus was increasingly on treating people ‘the same’ as other patients. In this stage therefore, CCPB was more aligned with a G construct and less of a DS one and notions of ‘sameness’ began to predominate. However, NQNs also were able to identify examples of

behaviour that demonstrated how they ‘prepared for’ rather than ‘responded to’ the perceived diversity characteristics of patients. Previous experience informed their care planning and decision making.

Communication was still a persistent cross-cutting theme in this second stage and whilst some challenges were still evident, participants were less likely to locate this challenge with the patient (i.e. a patient problem). They were more likely to describe this as a shared communication challenge and acknowledge the responsibility of the nurse to address this. Participants detailed the skills and strategies they used (both verbal and non-verbal) to meet the patients’ needs. Communication was considered an important skill in CCPB but also considered as relevant to communication more generally i.e. in relation to patients’ families, carers, their colleagues and the wider MDT. So, as CCPB became increasingly linked with themes that align it to a generic rather than DS competency, participants’ perceptions of their communication skills also followed this trajectory.

In stage three, the behaviour and actions that constitute CCPB were almost exclusively perceived as G and linked to core nursing concepts such as practising with compassion, individualised patient care, respecting individual differences, professional care and patient trust. However, CCPB as DS remained but more as an embedded feature of the nurses’ behaviour as it informed the assessment and planning of care (preparing for rather responding to patient diversity). In relation to communication, this was exemplified by ‘asking patients’ and checking understanding. CCPB therefore

involved NQNs pro-actively communicating with patients from diverse backgrounds to inform their assessment and planning of care. Uniquely in this third stage, another subtheme emerged not evident (explicitly) in previous stages; CCPB as dealing with complexity in nursing care. Caring for a patient from a diverse background was perceived as potentially adding complexity to care delivery. As DS actions or behaviours became more integrated into the G construct of CCPB, CCPB was associated more with 'usual care'.

Communication continued to be the central and most important skill that participants associated with CCPB. Communication was perceived as relevant to caring for, and interacting with patients with diversity but also a core nursing competency that was widely applicable to families, carers, peers, colleagues and the wider MDT. NQNs perceptions of the skills comprising CCPB were thus inextricably and predominantly connected with the importance of good communication both as a G and DS competency. Communication challenges (and language barriers) were again described by but on the whole these were considered ordinary and everyday challenges when delivering nursing care. Participants felt that their communication skills had developed as a consequence of caring for patients from diverse backgrounds. For others, CCPB was seen as related to and informed by, other nursing attributes such as (culturally competent) knowledge, awareness, sensitivity, desire or motivation. These attributes were perceived as important aspects to communicating with and caring for, patients from diverse backgrounds and were applied to the patient encounter.

As this study was concerned with understanding and identifying CCPB, the key behaviours described by the participants in relation to caring for patients from diverse backgrounds were collated. These are shown in Appendix 11 and these descriptions were mapped against the NMC Code (2015) to illustrate the connection between the two as well as differences. Where the descriptors provided by the participants matched with the NMC Code (2015), the relevant section of the Code is noted. In some case this was not explicit but implied within particular sections. It is evident from the information shown in Appendix 11 that some of the examples given by participants are easily mapped onto the NMC Code (2015). However for others, they are implied rather than explicit and remain open to interpretation. The Code represents a combination of values, skills and behaviours rather than a clear demarcation between these, or how they differ or interact. For example, there is a clear difference between the skills required of the nurse in terms of (18.4) "*take all steps to keep medicines sorted securely*" in comparison to the complexity implied in (2.3) "*encourage and empower people to share decisions about their treatment and care*". NQNs are required to challenge discriminatory attitudes towards patients (in prioritise people) but it is not explicit that the requirement (20.2) to treat "*people fairly without discrimination, bullying or harassment*" equally applies to colleagues or patients. Given the experiences of some nurses in this study, and the mounting research evidence of discrimination of BAME staff (West at al. 2017), one of the core skills for future nurses is understanding how to recognise discrimination in all forms and respond appropriately. Although the Code (NMC 2015) is an important guidance document for nurses it does appear to lack the

interpretative content evident in the ANA (2015) statements on ethics and professionalism, or provide clear demarcation between values, skills, and, or professional behaviours.

For the participants in this study, the development of their CCPB was dependent on and related to key construct two; the nurse in transition (NiT).

6.5.3 The Nurse in Transition (NiT)

The NiT construct was to some extent informed by the conceptual underpinning for the study design (see Appendix 6). Three interlinking core themes relevant to understanding CCPB were;

- Self-perceived Confidence and Competence (SPCC)
- Personal orientation (PO) (looking inwards or looking outwards)
- Personal and Professional Motivation (PPM)

These core themes were cross-cut by 2 other subthemes which were;

- Situational novelty versus situational comfort
- Support seeking novice versus integrated team member

6.5.3.1 Self-perceived Confidence and Competence (SPCC)

In the first stage of transition, SPCC was characterised by descriptions of their own lack of knowledge and, or experience caring for, and interacting

with, patients from diverse backgrounds. A perceived lack of knowledge regarding the particular needs of some patients resulted in perceived low competence and confidence in relation to CCPB. Challenging communication encounters was a linking thread throughout these descriptions. Perceived low competence and, or confidence in relation to CCPB promoted feelings of anxiety, helplessness and sometimes even distress. A key feature of low SPCC was being confronted by novel situations in terms of patient encounters (situational novelty). These novel encounters challenged or undermined the NQNs SPCC.

This was however, accompanied by reflection and insight into the potential impact of this on their practice. Participants expressed a desire and, or motivation to improve their practice and develop the knowledge and skills that they perceived they lacked (See PPM below). In addition, participants identified strategies to address these self-perceived deficits; primarily by engaging in support seeking behaviours. They sought support from peers and colleagues (often more senior colleagues) to advise, guide and direct them when caring for patients from diverse backgrounds. These support seeking behaviours were intentional, overt and visible to others and was perceived as an appropriate and legitimate strategy for the NQN. This was complimented by information seeking (policy and procedures). It appeared important that support seeking behaviours were met with a positive response. By stage two, participants' SPCC had changed, they were expressly more confident in their descriptions of encounters with patients from diverse backgrounds. The descriptions of anxiety and concern evident in stage one,

were no longer apparent. Thus, SPCC in relation to CCPB which was initially categorised as low was re-categorised as moderately high or high in this stage. Although participants still described situations in which they were sometimes challenged, they were not routinely describing situations or experiences that were novel to them. Situational novelty, a key defining feature of low SPCC in stage one was diminished or absent. With increased experience (and decreased situational novelty), participant support seeking behaviour in relation to CCPB also changed. That is; participants no longer provided examples that illustrated how they sought the support of others when delivering CCPB. Instead they described their actions and behaviours as sharing or communicating information to colleagues.

Thus as the NQN developed during the transition period (stage one to two), the novice nurse who sought support was replaced by a more confident practitioner who communicated proactively with colleagues regarding the care of diverse patients. In this stage and linked to the change in SPCC was the emergence of a discreet professional identity as a nurse accompanied by socialisation into the organisational culture of the workplace. This is exemplified by a change in the language participants used when describing themselves. In stage one, participants primarily used ‘I’ (the nurse) and by stage two, ‘We’ (the team) was equally common. In addition to this there was a greater awareness of the role and importance of ‘others’ (peers, colleagues) in terms of their CCPB. This increased awareness was also linked with PPM and PO (described in more detail below).

In stage three, participants continue to perceive themselves as competent and confident. Situational novelty in relation to CCPB evident in stage one and muted in stage two, now transforms into a concept situated along the same continuum but at the opposite end. Situational comfort. Participants feel part of the team, they consider themselves very much as nurses; qualified, competent and able. They are able to reflect back on their former selves and consider how they have changed. Their SPCC is high. Although they considered that they still had things to learn about caring for patients from diverse backgrounds, they were more confident in addressing knowledge and practice deficits. They rarely sought the support of others but instead sought knowledge and information (evidence) to improve their practice. Their descriptions of practice demonstrated how they networked with colleagues and, emerging in this final stage were examples of leadership behaviours.

6.5.3.2 Personal and Professional Motivation (PPM)

PPM to improve and develop as a nurse did not appear to diminish, it remained high throughout that stages although the motivation and drivers changed. PPM was linked to both SPCC and PO. In stage one, participants were concerned with their lack of knowledge and skills and their PPM was concerned with improving their skills and practice to deal with what they perceived as a deficit in their own understanding and ability. The recognition of their own limitations in terms of CCPB coupled with a low SPCC, served to strengthen PPM. Participants wanted to develop and become competent and

confident as nursing practitioners. PPM was however primarily driven by feelings of anxiety or a fear of being perceived as ‘stupid’ or of offending patients. Motivation and drivers were linked to their inward looking PO (see below). In stage one however, it is likely that PMM is also sustained by situational novelty; both in terms of the patient encounter and the new workplace environment.

In stage two, PPM as before remained high and NQNs continued to be committed to personal and professional development. However, as SPCC in relation to CCPB was higher, the motivation and drivers to develop were different. Professional identity and socialisation became important; the desire to be perceived by others (patients, colleagues, themselves) as a ‘good nurse’. This change in motivation was also linked with the changing PO from inwardly to outwardly orientated. As participants became less concerned with their own inner anxieties, they were more openly focused on the patient perspective and the wider clinical environment (families, carers and peers). The external influences on the participant became stronger in terms of PPM and participants became more situationally comfortable.

In the final, stage of the transition, participants PPM was similar to stage two. It remained more orientated to the external influences of patients and peers rather than internal drivers to improve CCPB. Participants were motivated to improve their CCPB as they wanted to earn the respect, trust and confidence of patients and colleagues and had a personal pride in the profession of nursing.

6.5.3.3 Personal Orientation (PO)

In the first stage, participant orientation (PO) was predominantly inward looking. Their primary concerns were their own perspectives, their own knowledge (or lack thereof) and the challenges they perceived in delivering care to patients from diverse backgrounds. Where these challenges were described, they were almost exclusively framed as located with the patient rather than seeing themselves within the interaction. This inward-looking self-fixated orientation was reinforced by situational novelty as they are primarily concerned with how they addressed their own knowledge and practice deficits (low SPCC). This inward looking perspective focused on their competencies and was linked with support seeking behaviours to improve.

By stage two, participants' personal orientation became more outward facing. Participants were more likely to be aware of the patient in the interaction and the patient perspective and were less concerned with their own anxieties and concerns. That is, as SPCC increased, PO changed from an inwardly looking orientation to a more outwardly orientated perspective. Challenges in caring for patients from diverse backgrounds were seen as shared and responsibility to address these (particularly in relation to communication) sat with the nurse.

This outward looking orientation was firmly established by stage three. Participants reflected more on their practice, actions and behaviours in relation to the patient and the wider organisation rather than merely reflecting

on their own feelings and perceived competencies and confidence. CCPB in this stage was linked with patient confidence in the nurses' competence. Participants' were also more aware of personal and organisational enablers and constraints. Specific reference was made to the importance of positive workplace culture (team working, leadership) on their practice and the relevance of their own personal diversity and experiences on patient care. Whilst time constraints and workload pressures were evident within the clinical environment, the behaviour of other patients, families and carers also impacted on participants' CCPB. Professional identity as a nurse was more embedded with continued socialisation into the role of nurse as team member.

6.5.4 Summary of the intersection of the two key constructs: CCPB and NiT

The development of CCPB's in NQNs is inter-related. Both CCPB and NiT changed through the nine months in which the participants were involved in the study. CCPB was perceived by NQNs as both a generic (G) and a diversity specific (DS) construct. The NiT construct (SPCC, PO, PPM) impacted upon and changed the conceptualisation of CCPB throughout the nine months of the study. As the self-perceived competence and confidence (SPCC) of NQNs increased, they became less inwardly orientated and more outwardly orientated (PO) and eventually CCPB became more aligned with G rather than the DS elements of practice. PPM remained a persistent and enduring theme throughout.

The purpose of this study was to explore NQNs perceptions of CCPB. NQNs experiences of engaging with patients from diverse backgrounds facilitated the development of skills and from the perspective of the participants their competence and confidence was increased. Organisational support was key to this development.

5.6 Conclusion

Participants learnt from experiences caring for, and interacting with, patients from diverse backgrounds as well as from others within their working environments. CCPB was perceived by participants as fundamentally linked to core nursing concepts such as individualised patient care, compassionate care and respectful care. Understanding and respecting individual differences were considered essential to establishing the nurse-patient relationship, engendering trust and underpinned by positive communication approaches. CCPB was seen as competent and professional nursing care (G) as well as actions or behaviours that could be undertaken to respond to the particular diversity needs of the patient (DS). As the nurse became more experienced at interacting with patients from diverse backgrounds, their self-perceived confidence and competence increased, they became more outwardly focused and more aware of others. Patients, families, their peers, and the wider organisational context was seen as relevant to the successful development and delivery of CCPB. The motivation to be perceived by others as a competent nurse drove their practice development.

Chapter 7: Discussion

7.1 Introduction

This chapter will explore the key findings that emerged from the data and critically discuss these within the context of relevant literature and contemporary healthcare policy, practice and professional standards. The relevance of the methodological, theoretical and conceptual framework to the findings will also be discussed (in Section 7.6) and includes personal reflections on the study and key themes that emerged. The chapter will conclude with an examination of potential limitations to the study. The unique contribution of this work to contemporary understanding of CCPB and recommendations will be addressed in the subsequent chapter.

7.2 Perceptions of Culturally Competent Practice Behaviour (CCPB)

The findings from this study suggest that CCPB was perceived by NQNs as consistent with the core nursing competencies and values enshrined within the Code (NMC 2015). NQNs must uphold and comply with all the standards of professional practice and behaviour detailed in the Code and the first standard (prioritising people) specifically states that all nurses are expected to "*make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged*" (NMC 2015: 4).

Consequently, it was to some extent unsurprising that the NQNs in this study articulated CCPB in terms such as practising with compassion, respecting individual differences, individualised patient care. In fact these common currency words permeate the majority of healthcare policy and practice in the UK (DH 2015) and professional guidance such as the RCN's Principles of Nursing Practice (Principle A) (RCN 2010) and The 6 C's (NHS England 2016b). Similarly, the language of compassion, inclusivity and individualised patient care is evident in professional guidelines, policy and nursing practice internationally (ICN 2012; OMH 2013; ANA 2015).

In the words of Allen et al. 2007, standards "*exude the rhetoric of professional language associated with the delivery of nursing care*" (2007: 49). Although some differences in terminology exist between countries, the core concepts referred to and language used has remarkable similarities, focused on reiterating the values of nurses and nursing as well as expected behaviours and standards. The importance and the relevance of these standards to NQNs cannot be overstated; they are persistently emphasised throughout pre-registration nurse education, form a central tenet of post-qualifying revalidation with the NMC and are prevalent in contemporary nursing and healthcare policy and practice (RCN 2010; DH 2010b; DH 2015; NHS England 2016b). These words, phrases and language were evidently embedded into the vocabulary of the participants. The overlap between the language used by participants to describe caring for patients from diverse backgrounds and the NMC Code (2015), is illustrated in Appendix 11.

The core concepts within cultural competence and its defining attributes (as discussed in Section 2.5.1) are consistent with contemporary language used to describe and articulate contemporary nursing practice. In particular, the focus on individualised or patient centred care (Saha and Beach 2008), respecting individual differences (Gallagher and Polanin 2014) and compassionate care (Papadopoulos et al 2016). Bray et al.'s (2013) study on the development of compassionate practitioners concluded that "*acting with warmth and empathy, providing individualised care and acting in a way you would like others to act towards you, were agreed as the most common understandings of compassion*" (2013: 485).

Compassion entails understanding the patient within the context of their lives, families and backgrounds and moreover showing respect for the individual (Lown et al. 2011; Curtis et al. 2012). However, not unlike cultural competence, compassion is poorly defined despite its universality in the nursing literature (Maxwell 2017). Although CCPB has not been operationalised within the NMC Code (NMC 2005) as a distinct and separate construct, in actual terms its core attributes can be routinely correlated with core nursing proficiencies, values and the language used to describe them.

For the participants in this study, the language of nurses and nursing care will have been assimilated during pre-qualifying education. However, language was also acquired and embedded as part of the professional and organisational socialisation of the NQN when they commenced employment

(Melrose et al. 2012). Professional socialisation enables the NQNs to learn the values, norms and behaviours of the profession, acquiring the professional identity of 'nurse' (Higgins et al. 2010; Rejon and Watts 2014; Phillips et al. 2015). This is a rite of passage for all NQNs, an accepted part of acclimatisation into the new 'community of practice' (CoP) (Wilson and Myers, 2000) and a necessary development in the transition period (Phillips et al. 2015; Adams and Gillman 2017).

The NQN begins the process of disconnecting from the student identity during the transition period (Kumaran and Carney 2014), previously meaningful reference points are lost and there can be incongruity between the former self (student) and new expectations within the healthcare environment (Curtis et al. 2012; Bray et al. 2013). The NQN moves from the periphery of the professional practice community as novice, gravitating towards its centre (Benner 1984). Explicit codes of professional practice and behaviour as well as informal workplace practices are learnt (Husband and Hoffman 2009). Over a period of time (the transition period), NQNs become active and engaged within the culture, start acting in accordance with the CoP norms and customs (Lave and Wenger, 1991) before eventually assuming the role of a competent expert (Benner 1984).

NQNs assimilation of the language associated with the delivery of nursing care is an important part of the socialisation process, as the language belonging to the group "*identifies and defines membership*" (Allan et al. 2007:

49). Participants in this study were keen to be perceived as a team member and a respected colleague and this desire to be liked and respected has been a consistent feature of the literature on the transition of NQNs (Rush et al. 2013; Phillips et al. 2015; Adams and Gillman 2017). As mentioned previously, participants increasingly referred to themselves as 'we' (the team) rather than 'I' (the nurse) in their accounts of practice as they progressed through the transition periods. Indicative of their perceptions of themselves as a team member, successful transition constituted "*being effectively socialised into, and supported by health services*" (Phillips et al. 2015: 119).

Professional socialisation was not unique to NQNs to the UK (Rush et al. 2013: Deasy et al. 2011) and appears to be applicable to experiences in different healthcare settings (Murray-Parahi et al 2016) and other professional groups such as doctors (Cruess et al 2015) and the police (Green and Gates 2014). Whilst the evidence recognises the importance of professional socialisation in NQN transition and its potential impact on retention (Phillips et al 2013, 2014), a distinction must be made between professional socialisation and organisational socialisation. In the latter, new employees within an organisation learn the relevant knowledge, skills and behaviours that they need to be successful in the workplace. This process Phillips et al. (2015) refers to as refer to as 'onboarding' (citing Bauer and Erdogan, 2011). Assimilating the language rules relevant to the particular organisation and workplace setting are part of this process.

Understanding the values of the organisation and gaining acceptance by colleagues are "*determinants of effective socialisation*" (Phillips et al. 2015: 120), but this is more closely aligned with the process of organisational socialisation which is context driven and specific to location. Workplace rules and language are likely to vary from setting to setting and the standards for CCPB are established and influenced by organisational values and norms, co-workers, patients and the NQNs own personal background and history. As argued by Numminen et al. (2015), these are not interdependent.

Professional socialisation on the other hand is more closely associated with notions of professionalism and professional identity. This was illustrated by the participants' desire to be perceived as a 'good nurse' i.e. one that was seen to exemplify core nursing values and behaviour. This can of course also be influenced by the organisational values and culture (Numminen et al. 2015b). Although these concepts are different, they are co-dependent. The professional and organisational socialisation of NQNs occurs simultaneously. These can however, result in conflicted situations for NQNs if for the example their professional identity (as caring and compassionate) was inconsistent and, or incompatible with the organisational culture or ethos in which they worked (Maxwell 2017).

The language used by participants did change during the transition process, initially their perceptions of CCPB were diversity specific and became increasingly more generic and universal. It might be that that this change in

language and terminology can be accounted for by the particular point in time in which the first directed reflections were completed. Immediately post qualification, participant perceptions of CCPB would likely reflect their pre-qualifying knowledge and understanding. The teaching of cultural competence at pre-registration level routinely presents this as an independent construct relevant to the care of patients from diverse backgrounds and not necessarily integrated across the whole curriculum (Calvillo et al. 2009; Jirwe et al. 2009). Consequently, perceptions immediately post qualifying are connected to this previous experience and education.

This particular view of CCPB thus dominated their perceptions as they entered the workforce (when the first directed reflection was captured) and the remnants of that language persisted into the first few months of practice before being gradually replaced by other words and terms that reflected the organisational context. As NQNs rejected the student identity, they also rejected the language of that identity and assumed that of the NQN (Maxwell 2017). In addition, the ambiguity and inconsistency inherent of the term cultural competence may be too abstract as argued by Gallager and Polanin (2015), this undermines effective transferability into practice, and the language of practice.

This replacement or exchange of the language NQNs use does not necessarily imply a negative impact on perceptions of patients from diverse

backgrounds. However, attention to words used is a core requirement of the symbolic interactionist approach as these are relevant to understanding the beliefs and attitudes that underpin these 'utterances' (Charon 2010). Focusing on the language more closely revealed that one particular change in terminology warranted further scrutiny. In the earlier stages, participants described circumstances in which they felt that a patient needed to be treated differently because of a perceived diversity characteristic. Respecting individual differences and treating people differently as a consequence of this is commonly associated with notions of diversity that is "*Valuing people and recognising them for their skills, talents and experiences, accepting that everyone is different*" (NMC 2010: 144).

However, in the later stages, instead of this being framed in terms of treating people differently, this underwent a transformation to treating people 'the same' as other patients, that is, connected with the notions of equality "*Treating everyone fairly and providing equal opportunities for everyone regardless of their race, gender, disability, age, sexual orientation, religion and belief*" (NMC 2010: 144). It is possible to argue that the change in language from diversity specific to generalised and universal conceptualisations of CCPB may be innocuous. However, the change in perception of people from diverse backgrounds from a perspective that is concerned with valuing difference, to one of equal treatment is potentially more concerning and warrants further exploration.

Understanding people from diverse backgrounds in terms of 'difference' and 'sameness' has a long history of discussion within the field of equalities and diversity management (Liff and Wajcman 1996; Gedalof 2012). The sameness or equal treatment model underpinned early equalities legislation, policy and practice (for example, equal opportunities) and was superseded by approaches which recognised the importance of difference and intersectionality in understanding and promoting social cohesion. However as Kirton and Greene (2005) noted "*the older equalities tradition lives on in policy and practice, even if it has been superseded in theory and rhetoric*" (2005: 114). Therefore one explanation might be that this has persisted within the workplaces in which the NQNs are located and they have adopted this choice of language and phrasing. Indeed, there is evidence to suggest that the public sector organisations are still attempting to understanding and integrate the implications of the Equalities Act (2010) and the duties imposed on public bodies (Shared Intelligence 2012; NHS England 2016a).

In addition, the fact that equality and diversity are terms that are used interchangeably (but erroneously) also serves to reinforce the message within organisations and workplaces that they have comparable meaning (Gedalof 2012). This may well represent a limited understanding on behalf of participants and they may see them as related and, or synonymous concepts. Indeed the NMC Code (2010) from which the above definitions of equality and diversity were taken, stated clearly after defining equality 'also see diversity'. The NQNs appear to have internalised a common misconception and confusion regarding diversity and equality and one

possible rationale for this is the organisational or professional socialisation process that occurs routinely as part of the transition experience. However, equally, this change in focus from treating people differently to treating people the same, from a diversity focus to an equality one could also represent a fundamental shift in attitude to people from diverse backgrounds receiving healthcare.

Whilst it was proposed earlier in this discussion that this change in terminology might be innocuous, further exploration of the language used identified the emergence of a new and unique theme in the final stage. This was a perception of CCPB as potential and actual complexity within the caring environment. As participants increasingly viewed CCPB as associated with more generic nursing concepts, caring for diverse patients was perceived as complex and not necessarily 'care as usual'. Although only four participants identified this particular issue explicitly (MSP 3, 4, 5 and 11), it was implicit in some of the comments made by others (MSP 6, 9 and 14). If treating people 'the same' is the dominant ideology then there is a danger that diverse patients might be perceived as 'not care as usual' or that 'usual care' related to those patients without perceived diversity characteristics. This re-framing of difference as other, difficult, potentially complex and challenging could be construed as an ethnocentric perspective (Kleinman and Benson 2006; Bennett 2009) and a barrier to CCPB (Cioffi 2003; Kai et al. 2007). In addition, the poorer health outcomes evident in some groups (ERHC 2010; Douglas et al. 2014) at the point of contact with healthcare services may serve to reinforce this perception of patients as having complex needs and

additional requirements. In essence, persistent health inequalities ensure that patients are both disadvantaged in terms of access and experience within healthcare systems as they may as a consequence of exclusion and systematic discrimination have care needs in excess of non-marginalised groups. Thus perpetuating and reinforcing perceptions of otherness as well as complexity.

Indeed MSP 11 specifically speaks of 'accommodating people' which represents an additional act or behaviour from the nurse. Accommodating differences reflects a traditional equality based perspective similar to equal opportunities (Liff 1996) but may represent a misconstrued or limited understanding of what is meant by recognising and valuing individual differences (Kirton and Green 2005). Equally, a notion of diversity which was more accepting and valuing of difference may have been diluted, replaced or superseded by a perception of people from diverse background as requiring accommodations, reverting to a equality perspective that has been superseded within the legislation if not in practice within nursing and healthcare.

Participants were thus recognising these individual differences and accommodating them but not necessarily valuing them and may be reflective of a more alarming tendency; that of 'repressive tolerance' (Brookfield 2007). Brookfield (2007), quoting Marcuse (A Critique of Pure Tolerance) argued that an all-encompassing tolerance of diverse views "*always ends up*

legitimising an unfair status quo" (2007: 558). Whilst this work focused on diversifying the curriculum in higher education, alternative viewpoints are presented as positioned in relation to the dominant ideology and by virtue of the comparison continue to be perceived, understood and interpreted as 'other'. The diversifying agenda that is accepting of all differences may (unintentionally) create or reinforce what Abrams and Moio (2009) refer to as 'color-blindness' which espouses tolerance but in effect is used to justify exclusion or inequality (Kirton and Green 2005). Given that four participants explicitly gave this perspective, caution must be exercised in interpreting this as NQNs holding potentially damaging and prejudicial views (Hart and Mareno 2013).

In addition, this may also represent another example of participants using the words, phrases and language of CCPB that they acquired during pre-registration education and then rejecting them in favour of organisational and professional specific language that is routinely used within practice. Participants may have espoused the language of diversity and CCPB as students as this was expected of them, as means to an end in terms of academic achievement and success. McColl et al. (2014) reported that students studying professionalism in the medical profession do and can 'game the system' in this way. Alternatively, as Gallager and Polanin (2015) have argued, these are abstract concepts that are not necessarily explored in the undergraduate nursing curriculum. Initial (pre-employment) understanding and conceptualisation of key concepts such as diversity, difference, equality or tolerance was not explored as part of this study.

Consequently, without establishing NQNs baseline understanding of these concepts these possible explanations remain conjecture.

Although it was of concern that some participants' understanding of CCBP was focused on treating everyone the same, there were other participants who were aware of the potential impact of their own assumptions regarding particular groups (MSP's 2, 4 and 14) and the importance of this awareness to the delivery of CCPB (Teal and Street 2009, Papadopoulos et al. 2016). For MSP's 2, 4, 6 and 8, CCPB was seen as fundamentally connected to delivering individualised, patient centred care. As Saha and Beach (2008) stated "*It should be readily apparent that many of the principles of cross-cultural care were the same as those for patient-centered care*" (2008: 5). Both CCPB and individualised patient care strive to improve the quality of healthcare delivery (Zhao et al. 2016) and there is significant conceptual overlap (Saha and Beach 2008; Gallager and Polanin 2014; Cai 2016) with a common requirement for holistic engagement with patients as individuals whose illness experience is located within a particular perspective and context.

7.3 Perceptions of the skills and behaviours of CCPB

Understanding the skills and behaviours that constituted CCPB was a primary focus of this PhD. The practice skills and competencies of NQNs are a key concern for the NMC (NMC 2010; 2014; 2015) as well as healthcare

employers (NHS England 2016b). Equally, the importance of practice skills are commonly cited within the literature on cultural competence (Krainovich-Miller et al. 2008; Allen 2010; Cai 2016), although explicit articulation remains imprecise (Ahmed and Bates 2012) and beset with conceptual ambiguity (Gallager and Polanin 2015).

In this study, participants recognised the need to provide culturally appropriate care and considered this important to patients. Patients want to be cared for by nurses who are aware and can adapt to their cultural needs (Tavallali et al. 2013) although patients' expectations as to CCPB remains underexplored (Chang et al. 2013). Participants' perceptions of CCPB were dominated throughout by a focus on communication skills. The importance of effective communication is a cornerstone of the NMC Code (2015), and in their Standards for Competence for Qualified Nurses (NMC 2014), care, compassion and communication constitute one core skill cluster. Communication skills are also central in models of cultural competence (Leininger 1992; Campinha-Bacote 2002; Purnell 2000; Papadopolous et al. 2016). Participant perceptions of the centrality of communication skills to CCPB appear valid and are consistent with literature and research in this topic area (Johnson 2004; Lampley et al. 2008; Teal and Street 2009; Kodjo 2009; Papadopolous et al. 2016).

The importance of communication skills was specifically highlighted by participants in all three stages and was a persistent and cross-cutting theme.

In the UK, all nurses are specifically trained in communication skills, this is a competency standard for qualification (NMC 2014) as well a professional requirement of the NMC Code (NMC 2015). However, this may not necessarily include cross or intercultural communication training specifically. Professional guidance has tended to be focused on formal processes relating to communicating within healthcare practice (sharing information, documentation, managing complaints) rather than the subtlety and nuances of communication between nurse and patient as a shared, interpretative, transactional and contextual process (Lustig and Koester 2010). Cross cultural communication (and other terms such as intercultural and transcultural communication) refer more specifically to communication encounters that effectively take place across cultural differences (Johnson 2004; Teal and Street 2009; Hemberg and Vilander 2017).

In the first stage, the focus was primarily on the challenges participants faced when language proficiency was not shared between nurse and patient. A common theme in the literature, language barriers appeared to be relevant to the experiences of UK nurses as well as internationally (EHRC 2010; Teal and Street 2009; Chang et al 2013, Douglas et al. 2014). Nurses are expected to "*take reasonable steps to meet people's language and communication needs*" (NMC 2015 Section 7.2), however it is not clear what 'reasonable' is meant in this context. It was evident that the participants in this study did not always feel competent or confident in meeting this standard. They felt challenged by the communication difficulties they encountered and this may have enhanced their feelings of anxiety and

frustration (Cioffi 2003), low confidence (Ali and Johnson 2016) and reinforced negative assumptions regarding patients requiring communication support. Effective communication skills are essential (Papadopoulos et al. 2016) to prevent cultural misunderstanding (Gan 2012), and these difficulties were perceived as a 'problem' residing with the patient (Teal and Street 2009).

Participants did however became more confident in their abilities to communicate and interact with patients from diverse backgrounds as they progressed to the next transition point. Participants were less likely to locate this challenge as being within the patient and were more likely to describe this as a shared communication challenge. The NMC Code (2015) is clear that all nurses must communicate effectively using "*a range of verbal and non-verbal communication methods and consider cultural sensitivities, to better understand and respond to people's personal and health needs*" (NMC 2015 7.3). Similarly, Douglas et al. (2014) specifically refer to the importance of verbal and non-verbal means in their guidance on implementing culturally competent care. However, despite its prominence within these guidelines its application to nursing practice is primarily concerned with cultural assessment and language barriers and are not necessarily applicable to other groups who may have communication challenges.

In terms of meeting the NMC standards, (NMC 2015), participants in this study provided examples of how they used simplified language (avoided

jargon) (MSP 9), provided information in an accessible format (MSP 8), in alternative languages (MSP 7) and used a range of verbal and non-verbal approaches to communicate (MSP's 4, 11). All these approaches were consistent with demonstrating effective cross cultural communication (Campinha-Bacote 2002; Johnson 2004; Papadopolous 2006; Kodjo 2009; Papadopolous et al. 2016; Hemberg and Vilander 2017) and advocated in standards to promote CCPB (Douglas et al. 2014). NQNs were also accessing information via other sources to support patients such as the internet and by involving patients' family members. Using family members to interpret on behalf of the patient is generally not advocated (Gan 2012), however it was evident that this approach was used by participants and for one, (MSP 4) family involvement served to further compound communication difficulties. Rather than using family members, the use of bilingual nurses may have provided an alternative option to facilitate communication (Ali and Johnson 2016) but this was not explored by participants, although specific reference was made to colleagues from non UK backgrounds.

When language proficiency was not shared by nurse and patient, non-verbal means of communicating were used rather than external agencies such as translation services or an interpreter despite a clear policy and practice mandate to do so (Gan 2012). The decision by individual nurses as to whether they needed to enlist external support was determined by whether they perceived they could 'get by' or whether they needed to 'get help' (Parsons et al. 2014). NHS spending in the UK has shown a 17% increase in translation services (2007/8 -12) and with increasing numbers of non-English

speaking people, demand is expected to rise (Gan 2012). However, as staff are also under pressure to make efficiency saving across all NHS services, 'getting help' may not be a decision that can be made by the individual nurse.

The emphasis on language barriers and the role of interpreters reinforces the idea that CCPB was seen as relevant to, and focused on, the ethnicity and, or nationality of the patients rather than a broader, more inclusive understanding (Abrams and Moio 2009). Interpersonal communication between nurse and patient is a dynamic two-way process and patients will derive the meaning of the nurses' behaviour from their verbal and non-verbal communication behaviours. The nurses' own culture and values are embedded in their communication behaviours and when "*differences between patient and practitioner mount, it becomes harder to communicate*" (Shapiro et al. 2002: 753). There may be discrepancy between the communication intention of the nurse and how it is perceived by the patient and vice versa (Hagman 2007; Husband and Hoffman, 2009). Whilst the NMC Code (NMC 2005) expects that NQNs are aware of how their behaviour can impact upon others, it is not explicitly related to communication behaviours of the nurse. This however is specifically referred to in the Standards for competence for registered nurses (NMC 2014). When patients are aware that they belong to a potentially stigmatised group they will looks for cues in the verbal and non-verbal communication of the healthcare practitioner that will either confirm or deny 'stereotype threat' (Aronson et al. 2013). The patient is thus aware of and alert to the possibility of stereotyping and this can impact on interaction between patient and providers. This can

be particularly acute when there is no shared language proficiency, however, even with a shared language, misunderstanding can occur due to different cultural interpretations of words (Johnson 2004).

Although, the NMC (2015) does expect NQNs to 'consider cultural sensitivities' when communicating, it is not explicit as to what this exactly entails in terms of delivering nursing care. Moreover, this assumes that the individual nurse has a sufficient level of cultural sensitivity and knowledge as well as the communication skills to deliver this. The nurses' assumptions regarding particular patients or groups of patients' impact upon and influence their communication approach and these assumptions may be reflective of ethnocentric beliefs and values (Lustig and Koester 2010). The standards for competence for registered nurses (NMC 2014) specifically referred to 'non-discriminatory communication' and the importance of NQNs being aware of "*their own values and beliefs and the impact this may have on their communication with others*" (NMC 2014: 9). The Code (NMC 2015) acknowledged the impact of the nurses' own values, beliefs and culture on their communication behaviours, but does not take into account the communication behaviours of patient and the inherent interactivity of communication.

Interpersonal communication is a two way process, dynamic and intersubjective and as Husband and Hoffman (2009) have stated, this is a "*less than perfect activity*" (2009: 20). Consequently there may well be

discrepancy between the intention of the communication behaviour from the nurse and how it is perceived by others (the patient). Few studies have specifically sought the patient perspective (Jirwe et al. 2009), although Harmsen et al. (2005) randomised controlled trial of the effectiveness of an educational intervention (video) on intercultural communication used pre-posttest measures on mutual understanding (of both patient and GP) and patient satisfaction and perceived quality of care using 986 consultations. Whilst no intervention effect was seen at one month, there was an effect at six months with perceived improvement primarily in mutual understanding. In this study, patients also were trained via the video intervention, further confirming the importance of communication of both parties in the interaction. This would appear consistent with Leininger's (1992, 2002) description of cultural care negotiation or 'cultural negotiation and compromise' (Naravanasamy 2002).

Also, challenging communication encounters were also cited by participants in relation to the communication approaches used by patients and, or families. Sadly, there were a number of examples of the family communicating with the nurse in an aggressive manner (MSP 3), or using language considered offensive to the nurse (MSP 1, 12). Whilst the onus is on the individual nurse to manage and respond to challenging communication encounters in a professional and compassionate way, this will invariably impact upon their relationship with individual patients. A concern acknowledged by participants in this study.

The NMC Code (2015) expects that NQNs should avoid making assumptions, and in the Standards for Competence for Registered Nurses (NMC 2014) there is a clear expectation that the NQN should be self-aware and "*recognise how their own values, principles and assumptions may affect their practice*" (2014: 7). This would however, be dependent upon whether individual nurses have received sufficient support and training to recognise and be aware of their own implicit biases and be able to understand the impact of these on their practice. Participants in this study did think that this was possible and this was part of being 'professional', but the findings would appear to suggest this continues to be a challenge for NQNs. Implicit and unconscious bias will manifest in behaviour and actions towards patients (White-Means et al. 2009; Teal and Street 2009). NQNs perceptions of the skills comprising CCPB were inextricably connected with the importance of good communication and seen as relevant to caring for and interacting with patients from diverse backgrounds but also a core nursing (generic) competency. Direct clinical experiences or cultural encounters are known to help embed the knowledge and skills of CCPB (Ingram 2012; Papadopolous et al. 2016). In this study, participants felt interaction (or exposure) had supported the development of communication skills, enhancing both competence and confidence.

Other than communication, the skills and behaviours of CCPB were often difficult to articulate by participants in this study and other attributes such as (culturally competent) knowledge, awareness, desire or motivation were cited instead. It may be that these other attributes were known components of

cultural competence and that participants being aware of the focus of the study considered these as relevant to the discussion. Equally tenable is the fact that they were unable to articulate the skills of CCPB because of the lack of conceptual clarity (Loftin et al. 2013; Horvat et al. 2014; Gallager and Polanin 2015). Given the interplay of the key domains and overlap evident in conceptualising these within the literature (see Section 2.5), it is understandable that participant considered these as skills. This may also demonstrate participants' awareness of the relevance and connectedness of these key concepts within cultural competence. They perceived these attributes as important precursors to effectively communicating with patients from diverse backgrounds. This is consistent with Papadopoulos (2006:18) in that these core domains must be applied and amalgamated with clinical and caring skills to demonstrate and communicate CCPB.

Thus communication and specifically cross-cultural communication or intercultural communication was not just an important skill, it was the skill of CCPB. Without communication skills, then the other domains within cultural competence models would fail to have a significant impact on CCPB. Arguably, a NQN could be culturally aware, knowledgeable and motivated but these abilities will not in isolation ensure that they are able to demonstrate CCPB. It is these communication skills that enable nurses' knowledge, awareness and sensitivity to be translated into effective CCPB and positive communication encounters with patients. Without these skills, 'supportive interaction' central to descriptions of cultural humility (Foronda et al. 2015) and cultural assessment (Cai 2016) cannot be initiated.

In this study, the application of the core domains of cultural competence using communication skills was exemplified quite simply by asking the patient. Participants took a pro-active approach to patients from diverse backgrounds and specifically sought information from them to better inform nursing assessment and care planning. This asked questions of patients to be able to pre-plan care and better meet patients' needs; a form of cultural assessment (Kim-Goodwin et al. 2001; Cai 2016). On one level this appeared to be a simple communication approach, however asking patients 'what matters to you?' is distinctly different to asking 'what's the matter'. The former question necessarily involved a whole person perspective underpinned by the principles of person centred care and respectful of individual differences. The latter, reflects patient (not person) centred care and perceives the person as a patient and a recipient of care delivery (Zhao et al. 2016).

Nursing assessment represents a systematic approach to understanding the health, needs and beliefs of patients and includes individual and idiosyncratic preferences in relation to backgrounds, culture and context. So whilst the NQNs may not be undertaking specifically a formal or detailed cultural or transcultural assessment (as in Giger and Davidhizar (1998) or Leininger's (2002)), they are engaged with the process of assessment using a person centered or individualised approach which has some consistency with these approaches. Cultural assessment advocated in the above models requires the nurse to gather data about a persons' culture, background, health beliefs and practices and care planning is not routinely performed or undertaken

consistently by nurses (Ballentyne 2016). As reported by Jirwe et al. (2009), nurses without of the US do not routinely include ethno-history as part of the assessment process, although Papadopolous (2006) considered that this was fundamental to the assessment process.

The quality of the assessment and whether it is person centred and, or includes a cultural assessment may depend upon the skills and competencies of the individual nurse. If as part of the assessment the nurse makes incorrect assumptions regarding the patient this can potentially lead to stereotyping, prejudice and discrimination (Kirton and Greene 2005) as well as unsuitable and inappropriate care (Shen 2014; Teal and Street 2009). Participants also provided specific examples of how they pre-planned care delivery based on previous experiences of caring for people from diverse backgrounds. Whilst on the one hand this demonstrated a development in their knowledge and confidence, some interactions with patients (of Muslim, Asian and Jewish backgrounds in particular) appeared to illustrate how cultural assessment had focused on simplistic notions of diversity by responding to primarily religious needs via food requirements.

Although, Leininger (1988, 2002) considered that particular religious beliefs regarding food should inform care delivery, heterogeneity in relation to nutrition and dietary practices was not assumed. This would result in assumptions being made without ascertaining preferences or individual differences (McClimens et al. 2014). Knowledge of cultural issues may

reinforce stereotypical assumptions or cultural generalities (Doutrich et al. 2014), as a consequence of an overly simplistic interpretation of patient needs (Kleinman and Beson (2006).

In relation to skills, whilst only one participant (MSP 5) explicitly stated that CCPB was in fact (just) nursing competence and not a distinct set of skills or approach. This perception was implicit in many of the comments regarding understanding and responding to individual differences. As this is the prerogative of all qualified nurses, it may be that the skills of CCPB as a distinct skill set are not distinguishable from generic nursing skills and consequently are difficult to describe and explain. Canales and Bowers (2001) in their study of Latino educators concluded that there was a "*perception that competent care includes cultural competency*" (2001: 106). As argued by Horvat et al (2014), it is important to distinguish between the generic knowledge or skills needed in the clinical encounter and specific knowledge needed about particular patient groups. Similarly, respondents in Jirwe et al.'s (2009) study noted that there are those qualities, values and skills that all nurses should possess and these are generic and are thus not distinct from cultural competence.

The distinctness of the skills of cultural competence needs to be further explored and disaggregated from what is considered core or generic nursing skills, behaviours or values. Reframing CCPB as exemplary nursing practice may be a legitimate approach to mainstreaming or embedding this within

everyday nursing care. If, CCPB is integrated into the core competencies of nursing as individualised patient care, this may also address the tendency for CCPB to be primarily associated with particular ethnic groups rather than applied inclusively and holistically. CCPB continues to be associated with the historical legacy of transcultural nursing and this persists into contemporary understanding of CCPB as espoused by one of the participants (MSP 14). The directed reflections provided by participants (See Table 4), were generally (although not exclusively) focused on ethnicity, race and, or religion. This lends some weight to the argument that CCPB is focused on particular characteristics rather than a contemporary understanding of CCPB which recognises 'protected groups' (as per the Equalities legislation) and intersectionality (FRA 2013).

Consequently, using the term CCPB rather than (just) nursing practice may be counterproductive as health care practitioners will continue to associate this with ethnicity, religion and race and fail to consider and respond to the inherent diversity of all patients (Abrams and Moio 2009). Reframing CCPB as exemplary nursing practice or embedding it into other contemporary nursing constructs such as compassion (Papadopolous et al. 2016) or individualised patient care (Saha and Beach 2008) may also mitigate against the perception that caring for people from diverse backgrounds requiring additional care or support, or being complex as discussed previously. If CCPB, is nursing competency then this becomes a core nursing skill or behaviour and every interaction and encounter is "*a cross cultural encounter*" (Like 2010: 29).

If CCPB continues to be considered as an add-on or adjunct to existing practice, then it continues to perpetuate the view of people from diverse backgrounds as requiring additional support in excess of non-diverse patients. Their 'otherness' persists and NQNs will continue to accommodate their difference whilst not fully valuing or appreciating it. However, whilst this argument has some merit it does not necessarily follow that embedding CCPB into exemplary nursing practice will impact on nursing practice, skills and behaviours. Equally, the causal relationship between seeing people as different or other and treating them as different or other is complex and rather than unidirectional is likely to be bi-directional each serving to reinforce the other.

The drive to reframe CCPB as culturally competent compassion (Papadopolous et al 2016) is understandable and a legitimate attempt to mainstream this into the contemporary nursing agenda. However, there are risks associated with this approach which may have unintended consequences. By continuing to discuss and debate cultural competence as relevant to contemporary nursing practice we ensure that this remains visible and prominent and continues to inform the debate regarding health inequalities, discrimination and the continuing disadvantage experienced by some groups of people. CCPB should not therefore be conflated with other nursing values, behaviours or competencies. Parallels with other similar concepts can be drawn to illustrate its relevance and applicability to both nurses, nursing and the patient experience. However, either losing the term cultural competence or in effect masking this within other professional

concepts runs the risk of diluting its potential impact and power. If we lose the language or terms of CCPB, there is a danger that the essence of this in care delivery will also be lost, forgotten or become invisible.

The equality paradigm of respecting and accommodating individual differences will persist and the historical legacy of the development of culturally competence and the lessons learnt in terms of challenging and changing nursing practice may be disregarded. Mainstreaming can create the illusion of embedding but may serve to undermine the magnitude of institutionalised discriminatory practice (Abrams and Moio 2009). The evidence would suggest that there is still significant work to be done to improve nursing practice in the area, therefore it may be premature to discard CCPB whilst health inequalities and experiences of discrimination persist (Shen 2014; Council of Australian Government 2014; NHS England 2016a).

7.4 Perceptions of facilitators and enablers to the development of CCPB

Participants in this study cited a number of different factors that potentially enabled and, or, hindered the development of their CCPB. There appears to be an assumption (both implicit and explicit) within the NMC Code (NMC 2014; 2015) that CCPB can be achieved upon qualification and the findings from this study would support the argument that that is not the case. The NQNs in this study did not see themselves as culturally competent (or culturally confident) upon qualification. Although awareness and knowledge

can be enhanced at the programme completion stage (Krainovich-Miller et al. 2008; Allen 2010; Gallager and Polanin 2014), the skills and behaviours to demonstrate competency are under developed. However, if we accept the argument that most NQNs are culturally aware but not necessarily culturally competent but that they do go onto develop competence in this area – the key question is how this developed, achieved and sustained in some but not others during the transition period.

Most NQNs have concerns regarding their skills and competencies when they first commence their new role and the 'reality shock' of transition identified by Kramer (1974) does not appear to have subsided in the intervening decades. Transition from student to NQN is complex and fraught with challenge and participants' perceived lack of competence and confidence in relation to caring for patients immediately upon qualification resonates with other studies (Cubit and Ryan 2011; Kramer et al. 2012; Rush et al. 2013).

However, perceived lack of competence and confidence in caring for patients from diverse backgrounds represented a distinct area of concern (Lampley et al. 2008) and in this study was linked to a fear of offending patients and, or 'getting it wrong' (Johnson 2009). In Kai et al.'s (2007) focus group study exploring responses to ethnic diversity of 106 health professionals, they concluded that "*uncertainty may disempower professionals, creating hesitancy and inertia in their clinical practice to the potential detriment of*

patient care" (2007: 1770). Consequently, fear of being perceived by the patient or colleagues as discriminatory or causing offense undermined confidence and the notion of cultural confidence is an area of research that warrants further investigation and research going forward. Cultural confidence may well be specific to NQNs in that they lacked confidence generally during this particular stage of their careers. However, Chang et al. (2013) reported on a cross-sectional survey of cultural sensitivity in 230 nurses and found that interaction confidence was scored the lowest across a range of self-report measures on cultural competence. Consequently, cultural confidence (or interaction confidence) may also be an issue for more experienced nurses (Kai et al. 2007; Chang et al. 2013). Participants' concerns in relation to 'getting it wrong' may also be linked with rising managerialism within UK and international healthcare provision. Nursing has become an increasingly regulated and performance orientated profession (Stone et al. 2011). Failure to perform to the appropriate competency standards advocated by the Code (NMC 2015) or in line with organisational directives on equality and diversity carries potentially significant consequences for individual practitioners.

Inappropriate behaviour or language in relation to a patients' cultural identity may be perceived as leading to possible accusations of discrimination from patients, colleagues or managers. In the post Francis era of healthcare provision, negative patient experiences regarding the behaviour of nurses are being taken very seriously (DH 2015; NHS England 2016b) and participants fear of 'getting it wrong' may be magnified within a context of scapegoating

individual nurses. There is significant inconsistency in the interpretation and application of disciplinary procedures within healthcare systems (Stone et al. 2011). Consequently, raised awareness of patient complaints and the potentially punitive response from managers in relation to staff lacking cultural competence may have heightened participants' concerns regarding CCPB.

All of the NQNs in this study would have had interaction with patients from diverse backgrounds as part of their pre-registration education. However it is important to note that there is a fundamental difference between being a student (as supernumerary) when compared to the status of qualified nurse in relation to professional accountability. As Dearnum (2000) has suggested; accountability is not a skill that can be rehearsed. The support and supervision which was a key defining feature of the student experience is withdrawn, absent or limited and the fear of making mistakes united with an awareness of increased accountability creates significant anxiety (Numminen et al. 2015). NQNs are challenged by their change in status and the responsibility and accountability that this entails and Blakey and Jackson (2016) described it thus "*the weight of responsibility and accountability has hit me like a tonne of bricks*" (2016: 1). The sudden increase in responsibility and heightened awareness of professional accountability make NQNs more sensitive to patient and managers' concerns regarding their practice.

The experiences of ‘newness’ are also consistently reported in the literature on transition (Kelly and Ahern, 2008; Higgins et al. 2010; Kumaran and Carney 2014; Blakey and Jackson 2016,). In this study, this newness was understood to reflect participants’ experiences in terms of situational novelty. That is, the novelty associated in relation to the new role, caring for and interacting with diverse patients and the workplace setting. These three aspects of situational novelty were inter-reliant and served to reinforce each other during these early experiences combining together in culture shock (Kramer 1974) or transition shock (Duchscher 2009).

A key enabler for the NQN’s in terms of progressing from the initial experience of transition shock appeared to be the ability of the participants in this study to reflect upon their concerns and perceived limitations. Both the NMC Standards for Competence for Qualified Nurses (2014) and NMC Code (2015) place a clear expectation on NQN to be self-aware and know their own limitations regarding their practice. Awareness and insight into the challenges they experienced particularly in relation to communication drove their engagement with specific behaviours to enhance development.

Immediately post qualification, this was characterised by engaging in support seeking behaviours from peers and colleagues (often more senior colleagues) to advise, guide and direct them. Similarly, the importance of critical reflection to the delivery of CCPB is evident in US guidelines (Douglas et al. 2014) as well as in work in New Zealand on cultural humility (Foronda

et al. 2015). Whilst the ability to critical reflect upon encounters with patients from diverse backgrounds is evidently important, the learning that emerges from that critical reflection may well require supportive colleagues and a positive organisational ethos to effectively translate this into future practice. The importance of facilitated learning opportunities was a key finding in Adams and Gillman's (2017) study. Colleagues and peers within the workplace play a crucial role in ensuring that opportunities to develop and, or enhance skills form part of the transition experience. Although CCPB was not specifically considered in this review, this is transferable and applicable to NQNs and CCPB.

The importance of support during transition has been universally acknowledged in the literature (Higgins et al. 2010; Kramer et al. 2012; Kumaran and Carney 2014; Adams and Gillman 2017). One to one support is generally advocated and in the UK this usually takes the form of a preceptor and a designated supervised period of preceptorship (Currie and Watts 2012, Whitehead et al. 2013). Although studies were generally in agreement as to the importance of support for successful transition, most studies evaluate individual models rather than compare efficacy of approaches (Adams and Gillman 2017). Whilst, approaches and frameworks of support in transition do not specifically address the impact of this on CCPB, good practice in the support of NQNs equally applies to the development of skills, competence and confidence in caring for patients from diverse backgrounds.

In the UK, Currie and Watts' (2012) review of preceptorship concluded that there was little or no evidence as to clinical or cost-effectiveness of this type of provision. Given this, the impact of this approach on health inequalities and outcomes for patients from diverse backgrounds must also be questioned. However, in terms of NQNs developing CCPB, the cultural competence of the immediate supervisor (or preceptor) has been seen as critical (Burkard et al. 2006; Inman 2006; Constantine and Sue, 2007; Dressel et al. 2007). Although this body of work is primarily focused on CCPB as related to transcultural nursing practice, it is consistent with studies on transition that emphasis the vital role colleagues and peers within the workplace play in supporting skills development and confidence (Adams and Gillman 2017).

However, despite the lack of evidence in the UK as to the impact of preceptorship this approach persists. In this study, few participants specifically mentioned preceptors as enablers (or preceptors at all) and one participant (MSP 9) cited a poor experience with a preceptor. The majority of the NQNs spoke positively about their workplaces and the importance of a positive workplace culture (Starr and Wallace 2009). The focus on peers and colleagues as part of the healthcare team would appear to more reminiscent of the group approach advocated in US (Figueroa et al 2013) and Canadian (Hunsberger et al 2013) models. In addition, Rejon and Watts (2014) in their evidence review of nurse socialisation concluded that although they did not find a direct link but "*an effective team is a more beneficial environment in which to be socialised*" (2014: 6).

It may be that the NQNs in this study are unique in relation to experiencing preceptorship. However, in Doody's et al.'s (2012) survey of transition, 65% of NQNs expected to receive formal support via a preceptor and only 29% actually received it. The experiences of the NQNs in this study may be representative of more contemporary team-based models of support that exist within healthcare practice. Given workload pressures, staffing shortages and a lack of available or suitably qualified preceptors (Deasy et al. 2011; Whitehead et al. 2013) less formal and more group (or team) based approaches to managing transition might be beneficial (Adams and Gillman 2017). However, the absence of formal support systems are of concern in relation to CCPB as opportunities to discuss culturally sensitive issues might best be managed within a one-to-one support structure.

However, what emerges from this study in terms of understanding CCPB was the relevance of the wider team to the NQNs experience. Understanding NQNs competence requires an understanding of not just the individual factors but the wider organisational context and environment in which the NQN works (Numminen et al. 2015a). Multi-disciplinary team working is a key feature of contemporary nursing practice and whilst the individual preceptor may be important as both role model and supportive colleague, they are not the only person that exerts an influence on the NQN. Equally, an understanding of this wider context must include patients, their carers and families who are increasingly not passive recipients but active partners in care delivery.

The wider workplace and MDT have a significant influence on the professional socialisation of the NQN (ten Hoeve et al. 2014) and on the knowledge, beliefs, values and skills that they develop during this period (Dinmohammadi et al. 2013). The workplace culture embodies the values of the organisation (Phillips et al. 2015) and for NQNs seeking to improve their CCPB, a positive workplace culture was characterised by supportive colleagues, positive role models and exemplary practice, all elements that feature in frameworks of culturally competent organisations. Participants spoke positively of their workplaces and did not appear to experience what Maben et al. (2006) referred to as 'professional sabotage'. In terms of requiring support to provide care for patients from diverse backgrounds it was important that requests for advice or support were responded to positively and colleagues were seen as supportive and facilitating rather than dismissive or belittling (Kramer et al. 2012; Phillips et al. 2013; 2014). Given the anxiety experienced by the NQNs in this study in terms of 'getting it wrong' (Johnson 2009), a negative response would have further undermined their self-perceived confidence and competence (Maben et al. 2006; Kelly and Ahern 2008; Feng and Tsai 2012; Kramer et al. 2012). By being reflective, participants were able to understand and acknowledge the challenges they faced and then engage in appropriate and legitimate strategies in order to improve their competence and confidence.

Seeking constructive feedback from others diminished as the NQN developed and they increasing described themselves as a more confident practitioner who communicated proactively with colleagues regarding the

care of diverse patients. Participants did not overtly seek the support or validation for their actions from others; rather they described their actions and behaviours as sharing or communicating information to colleagues. Duchscher (2008; 2009) has previously described NQNs as feeling abandoned as support was increasingly withdrawn but participants in this study provided no accounts of this phenomenon. The participants appeared comfortable in relation to their qualified nurse status by the six month time point, more confident in caring for and interacting with diverse patients and were accustomed to the workplace environment. Professional and organisational socialisation and integration appeared to have occurred for the participants in this study (Price 2009; Dinmohammadi et al. 2013; ten Hoeve et al. 2014).

Adams and Gillman (2017) recommended three key elements for NQNs; support, socialisation and facilitated learning opportunities. In relation to the latter, participants in this study did not explicitly refer to any formal or structured systems or processes that they were exposed to such as discussions, communication or conflict resolution, stress management or critical thinking and problem solving. They were however, given opportunities to share experiences with others and as the focus of this study was not exclusively on participant perceptions of strategies to facilitate learning during transition, this may well explain this lack of detail.

How best to support NQNs during transition to promote retention in the workforce continues to be a core concern for the NHS and healthcare providers (Whitehead et al. 2013). It is recognised that if an organisation is not sufficiently supportive, this can compound NQNs nurses' levels of dissatisfaction and disappointment. The organisational context in which the NQNs worked was of paramount importance in facilitating their personal and professional development and impacting positively on their self-perceived competence and confidence (Rejon and Watts 2014). Although this study explored individual perceptions of CCPB and the organisational context of care was not measured directly, participant responses demonstrated the relevance of understanding CCPB as an interaction of individual factors and the organisational context of care (Numminen et al. 2015).

Personal and professional motivation to improve and develop as a nurse appeared to be a key driver in terms of the change from novice nurse to fully autonomous practitioner. NQNs were more confident in addressing perceived knowledge and practice deficits and using evidence based practice in the latter stages of transition than in the former. The importance of lifelong learning was recognised as an essential part of being a nurse and nursing (NMC 2014; 2015). Studies exploring stages of transition in NQNs differ in their views as to when autonomy has been achieved (see section 2.6.3). By five to six months into the role, the NQNs in this study were expressly more confident in their interactions with patients from diverse backgrounds as well as in relation to their role and competencies generally.

It could be that this was sufficient time for situated learning to occur (Wilson and Myers, 2000) and for successful socialisation and acceptance into the professional practice community to take place (Cruess et al. 2015; Phillips et al. 2015). Equally, the professed competence and confidence of nurses in this study can be seen as illustrative of what Benner (Benner 1984) described as the competent or proficient stage. However, Benner (1984) did not consider these stages to occur until two or three years into the role. The participants in this study experienced a transition that was more equivalent to the NQNs in Lima et al.'s study (2016) in which the first six months are significant to competency development. As argued previously although Benner's (1984) ground breaking work into transition remains relevant as a model, the timeframes may no longer be applicable to the experiences of today's NQNs.

One final enabler to the development of CCPB that was discussed by participants was the impact of their own personal experiences of diversity. This was seen as enabling positive insights into the experiences of patients with diverse backgrounds and providing a cultural context to the assessment and delivery of care. This would appear consistent with the wealth of evidence on the importance of a diverse nursing workforce both in the UK and internationally to facilitate cultural competence (Williams et al. 2014; West et al. 2015, Glaser et al. 2015). This extended to having family members who were from diverse backgrounds and providing insight and empathy with the needs and preferences of particular groups. The background of the NQN and their personal experiences, culture and context

provided not just knowledge but understanding, insight and appreciation of the potential impact of diversity on the individual patient experience. This may as Chang et al. (2013) reported be related to increased cultural sensitivity. Personal diversity was considered an asset for several of the participants in this study (MSP 1, 4, 8, 9, 13) although it could also have a negative impact on working experiences. This is discussed further below in 7.5 and specifically relates to participants who identified as being from a BAME background.

7.5 Perceptions of barriers and limiters to the development of CCPB

As participants became less fixated on their own competence and confidence, their awareness of external influences including potential barriers to the delivery of CCPB also increased. Whilst factors such as the time pressures, staff shortages and workloads issues were evident in this study there was an almost universal acceptance of this as just usual functioning within healthcare settings (NHS Employers, 2010). Maben et al., 2006 described this as 'organisational sabotage', and although the data from this study was collected in 1997-2000, the relevance of these factors to contemporary practice continues to be at the forefront of discussions regarding safe staffing and nurse retention and wellbeing in UK health services (Kings Fund 2017).

In addition, resource issues (time, money, and training) are a known impediment in the delivery of cultural competent care (Starr and Wallace 2009; Hart and Mareno 2013). Workplace benchmarks and standards on cultural competence of organisations (see for example Global Diversity and Inclusion Benchmarks (O'Mara and Richter 2006; Competency Framework for Equality and Diversity Leadership DH 2011) all cite similar factors as barriers to effective cultural competence of both organisations and individuals. In the US, despite the OMH advocating the implementation of the CLAS Standards (OMH 2013) there are still challenges with delivery including a lack of awareness of the standards, staff training issues, gaps between patient and provider in relation to communication and knowledge and a lack of leadership (Barksdale et al 2017). However, in this study, the organisational factors that may hinder the development of CCPB did not emerge as distinct with participants citing broadly similar workplace pressures to other studies on transition (Higgins et al. 2010; Kramer et al 2012; Kumaran and Carney 2014).

These barriers to successful transition; lack of support, ineffective professional socialisation and lack of learning opportunities (Adams and Gillman 2017, Figueroa et al 2013, Hunsberger et al 2013) did not appear to figure in participant accounts of their experiences of practice. It may be that participants did not wish to share their negative experiences or speak critically of colleagues or the clinical environment in which they worked. The barriers were specifically discussed within the interviews and it may well be that their self-perception as one of the team and part of the professional and

organisational culture precluded it. The experiences of participants from a BAME background in terms of integration into the professional practice community may have been different to that of participants from non-BAME backgrounds (Cruess et al. 2015). Being critical of colleagues and, or the workplace environment could be perceived as either challenging or rejecting the norms and values of the profession and the workplace culture (Phillips et al. 2015).

As the study was focused on individual perceptions of CCPB, the organisational competency could only be inferred from the participant accounts. If the organisation is not culturally competent then, the NQN is influenced by cultural, socio-cultural, psycho-social and environmental factors within the organisation that are in opposition to the expression of authentic CCPB (Gudykunst and Kim 2003). As argued earlier this may account for the change in language used to describe caring for patients from diverse backgrounds. Via a process or organisational and professional socialisation, the NQN has accepted the 'unwritten' and 'invisible' rules of the organisation (Husband and Hoffman 2009) and these may or may be not be consistent with the delivery of CCPB. This could however only be inferred from the participant responses as this was not directly observed or recorded as part of this study. So whilst this assertion would appear to have some plausibility, it was not immediately verifiable by the study findings. In addition, participants provided numerous examples of working within a diverse nursing and healthcare workforce and this is considered an important antecedent to CCPB (Williams et al. 2014; West et al. 2015; Glaser et al. 2015).

Whilst some participants considered that personal diversity was an asset (MSP 8 and 13) when providing care, for others (MSP 1, 9) this had created challenges in the workplace especially in relation to engaging with families and carers. There is a wealth of evidence to suggest that internationally educated nurses (IEN) experience discrimination in the workplace from patients and families (Wheeler et al 2014, Klein 2012, Likupe and Archibong 2013, Archibong and Darr 2010). The way families and carers communicate with healthcare staff can adversely impact upon the professional-patient relationship particularly if the communication is considered discriminatory.

For the nurse, the communication behaviours of the patient can have a considerable impact upon their experience and interpretation of events. Just as nurses and other healthcare professionals may have implicit biases (White-Means et al. 2009), patients too may hold discriminatory and prejudicial views (Wheeler et al. 2014). Underpinning these communication interactions, is an assumption that the nurse is unable to provide safe, effective and competent care because of their skin colour or nationality. The NQN in this study who spoke of experiencing discriminatory attitudes and behaviours from patients were non-white British but all participants had all completed their nursing qualification in the UK and were not IEN's.

However, whether educated in the UK or without of it, these experiences of discrimination appear to be pervasive. In Wheeler et al.'s (2014) US study, IEN's were more likely to experience explicit discrimination however it was

also experienced by White-American and African- American nurses. They concluded that these experiences of discrimination "*were not limited to one hospital, one state or one geographical region, indicating the pervasiveness of the behaviour*" (Wheeler et al. 2014: 353). Similarly in the UK, IEN and BAME staff face covert discriminatory attitudes and behaviours from patients, families, colleagues and managers (Likupe and Archibong 2013). For MSP 3, this experience caused concern and personal stress regarding the potential impact of this on the relationship with the patient and their family.

Nurses who experience racist discrimination 'constantly scan people' to work out how best to approach the nursing role (Wheeler et al. 2014) and determine how best to deliver care to a patient (Likupe and Archibong 2013). This is not dissimilar to the concept of 'stereotype threat' experienced by minority patients and highlighted by Aronson et al. (2013). This constant scanning is stressful and demoralising and whilst violence towards staff from patients or families is not tolerated within healthcare settings, there appears to be a more measured response to covert discrimination. The onus is often on the individual nurse to be tolerant of discrimination from patients and their families, downplaying concerns (Archibong and Darr 2010).

7.6 Reflecting on the study findings with reference to the methodological and theoretical frameworks

7.6.1 Introduction

The data provided by the participants was analysed and approached via a distinct methodological lens and this was outlined in Section 4.5. Using an interpretative methodology derived from constructionism and informed by symbolic interactionism (Crotty 1998, Earle 2010, Pringle et al. 2011) provided a means by which to explore and explain the meaning NQNs ascribed to their experiences. Importantly for this study, the approach taken recognised and valued that the meaning of CCPB was influenced and informed by the culture and context in which they interacted with patients and engaged in healthcare delivery. In addition, my own participation in generating meaning and understanding of the phenomena via analysis would inevitably create an interpretation of CCPB that might be different and, or the same as the participants in this study.

7.6.2 Reflecting on data analysis and integration

All analysis within a phenomenological perspective necessarily involves reflection, and this can be undertaken in a structured way but equally allowed for intuitive emergence of ideas (Cresswell 2013). A purposeful self-awareness was required to both acknowledge and challenge my own ‘taken for granted’ thinking throughout data analysis to inform interpretation and

discussion of the findings and explore unspoken meaning through critical self-evaluation (Berger 2013).

During analysis, the key challenge was organising and interpreting the data when simultaneously submerged within it. Throughout this process, I was mindful of whether I was being subjective in this process (involved in, or had an influence on, the outcome) or objective (distanced from, or independent) in the execution of the analysis (Krauss, 2005) and the potential for my own subjective experience and interpretation to influence the creation of meaning (Drake 2010). A reflective journal was used to note assumptions and potential preconceptions to remain self-aware and open to meaning within analysis. As the participant data was analysed in sequential order, with each new story I examined, I was aware that I was simultaneously thinking about and considering what other participants had stated in their interviews and directed reflections. Consequently, analysis of the later stories were influenced by my 'meaning making' in the earlier analysis.

As my immersion in the data progressed and my understanding developed, it was necessary to check my original perceptions of the earlier stories for two key reasons. First, this was to ensure that I had not missed something of significance in stories I had analysed earlier on and secondly to re-examine these in light of the later stories. At this stage I also examined my earlier reflections on what I considered CCPB to be, in order to examine the extent to which my own perceptions might be dominating and, or directing the

analysis (Rapport 2004). The creation of the collective stories were also examined to consider whether they were reinforcing my own assumptions about this area of practice and explore the possibility that stories that challenged my views has been minimised and, or dismissed (Marshall and Rossman 2011).

Mapping the data into a visual format was a useful step in order to distance myself from the text temporarily and consider in more detail how the themes connected and intersected with each other. By approaching the data in this way I was able to distance myself from empathic engagement with the individual stories and see the data more openly and honestly in terms of key constructs and themes. In the final section, the data integration the study objectives and research questions were re-examined to provide a reference point and maintain the focus of the final analysis. By doing this, it was possible to determine what was (and what was not) relevant and to be selective and intelligent with the data (Finlay 2014).

The visual maps of the data were examined all together to see how the themes had progressed over time that is, how themes had increased or diminished, changed focus or orientation, developed or disappeared during the transition period. The focus remained throughout on the nature of the phenomena being explored i.e. what does CCBP mean to individual practitioners and how they defined and interpreted this in order to distinguish the essential features of the phenomena (Moore, 2010). I was aware

throughout my writing of the discussion to what extent the themes generated resonated with, or challenged my own pre-conceived ideas and assumptions as this may have undermined or influenced my analysis and discussion (Berger 2013).

NQNs perceptions of CCPB did not entirely fit my own preconceived ideas although I recognised the generic and diversity specific elements of CCPB. From my perspective, CCPB was simultaneously both of these and was mediated by professional judgement and clinical decision making. I did not expect that CCPB would become more generalised as the NQNs progressed I expected it to become more detailed and informed reflecting their additional experience. This assumption was informed by my understanding of literature on CCPB. Equally I was aware that this expectation was also directed by my hope that participants would illuminate the skills and competencies of CCPB, providing concrete examples of this in everyday practice to share more widely.

Having both studied the topic of cultural competence and also taught this at pre-registration nursing levels I was aware that there was some ambiguity as to what actually constituted CCPB. So my expectations when I commenced the study was that my research would add clarity to this debate. However it appeared that ambiguity still persists and further research is needed. Given that this was a volunteer sample and participants were likely to have been interested in the topic area, the fact that they did not appear able to fully

articulate this concept was initially perplexing. It was only through exploration of the data within the context of the literature that I was able to better understand their responses. They were unable to fully articulate CCPB in the way that I hoped because it is difficult to articulate and my initial disappointment reflected my own expectations and hopes rather than their abilities. In addition, I was aware that my own upbringing, family context and community (see Section 1.3) had made me acutely aware of the discrimination faced by some groups in society and had instilled in me a strong sense of the need to challenge inequality. It was consequently important to me personally that I was able to find a way of contributing to developing a better understanding of CCPB within my profession.

The purpose of using a qualitative methodology was to seek to understand the personal experience of participants in their own words, allowing the meaning to surface via analysis rather than imposing my own expectations (Marshall and Rossman 2011). It was important to continually remind myself of the need to aspire to empathic neutrality as advocated by Ormston et al (2014). So, instead of searching the data for content I personally wanted and hoped to see, I had to examine the data in terms of what the participants actually said. Questioning participant accounts and considering alternative viewpoints to my own was a useful starting point. However, using others including supervisors and peers within an Action Learning Set provided opportunities for my interpretation to be debated and, or challenged. Meaning-making within the context of discussing qualitative findings was an immersive experience but can be isolating as well as done in isolation. Using

‘critical friends’ provided an opportunity for own interpretations to be subject to external scrutiny and feedback to inform further reflection.

Whilst participants did not fully articulate CCPB entirely in the way that I had hoped, they were able to explain and discuss the centrality of communication to CCPB and provide discreet examples of its use in practice. The focus on communication as a key skill within CCPB was discussed earlier in this chapter. Although I expected that communication would feature I had not anticipated that this would saturate participant accounts in the way that it did. The fact that this was in contrast to my preliminary assumptions and expectations adds further legitimacy to participant perspectives as this finding emerged from the data rather than being imposed upon it (Bazeley 2013).

The process of professional and organisations socialisation of the participants in this study did have some synergy with my own reflections as a NQN. The low self-perceived competence and confidence was very much connected to my own recollections of this time although I was aware that these contemporary nurses were discussing situations and contexts different to my own. Acquiring the words, phrases and language of nurses and nursing was part of my own rite of passage and whilst I was aware of my own attempts to be respected by my colleagues although the notions of professional and organisational socialisation were unknown to me at that time. Equally, the participant accounts did not appear to reflect an insight

into these particular constructs and thus I had interpreted their experiences using this prior knowledge and understanding.

Similarly, I shared with participants an understanding of the importance of peers, supervisors and role models during transition into practice and this support from others was pivotal in terms of my own personal and professional development. This aspect of professional and organisational socialisation does not appear to have lost its value or impact despite thirty years separating the experiences of the participants with that of myself. I had assumed that the NQNs would have a nominated person (a preceptor or supervision) and that they would refer to this person in their accounts. As the preceptorship model predominates in the UK, it was not unrealistic to expect this to have prominence in participant accounts. However, despite, these nominated persons being specifically referred to by myself in the interviews in the form of prompts, only two participants referred to their preceptor and for one this was in a negative context. By reflecting on this peculiarity within the participant accounts I concluded that this may be accounted for by a lack of available preceptors within practice or alternatively that their role or contribution is not as influential or significant considered in previous research (Whitehead et al. 2013, Deasy et al. 2011).

There was one area in particular that caused me most consternation during analysis of the findings and opened up challenges in terms of my personal and intellectual understanding of nurses and nursing. This related to some of

the language and terms used by NQNs when describing patients or clients and included phrases like ‘bed-bound’ and ‘he was all care’ (to describe an immobile patient). Previously I have undertaken research involving older people, a project called ‘Taking Care with Words’ (Draper et al. 2013) which explored the impact of words used by nurses or caregivers. This has informed by understanding of the importance of choosing words carefully when describing people, and I considered such language was disempowering. I was also surprised that contemporary nurses used these kinds of terms and they seemed incompatible with, and contradictory to, other words used by participants such as compassion and respect. The Francis Inquiry (2013) highlighted that the words nurses use when talking to and about patients matter to their sense of dignity. In addition, when it appeared that language used by NQNs to discuss caring for people from diverse backgrounds has changed from using terms associated with difference to that of sameness, I was initially unconcerned. The more I reflected on this and explored the data, what had appeared inconsequential became increasingly important and relevant to my understanding of their experiences.

7.6.3 Reflecting on data analysis and the findings with reference to Symbolic interactionism

Careful scrutiny of the raw empirical data with a focus on language was pivotal to adhering to the symbolic interactionist approach (Charon 2010). Thus, in analysis revealing the meaning that people ascribed to CCPB

focused on examining the words and language they used to describe their experiences. Focusing on the language (spoken or written words or phrases) that people use presents a challenge for the qualitative researcher as they may or may not have shared meaning. Misinterpretation is always possible.

Individuals create meaning; words as symbols. These are shaped by the social world in which they interact and this continually evolves (Byrne and Hayman 1997). Participants were specifically asked to describe their actions and behaviour over a period of time (9 months). Developing a continuing relationship with participants and understanding their on-going perceptions and interpretations of CCPB throughout this time facilitated an understanding of what Blumer (Blumer 1969) referred to engaging with the 'sphere of social life'. In this study, this referred to the individual world of the participants as it intersected with the organisational context of care provision in which they worked. One of the values of using an approach informed by symbolic interactionism was that it provided a focus on incorporating the social aspects of interaction rather than merely the psychological or biological. This then facilitated an understanding of CCPB from a different viewpoint.

It is this focus on definition, interpretation and meaning making that illustrates symbolic interactionism in action as opposed to the measurement of observable behaviour within the behavioural tradition (Benzies and Allen 2001). Participants' own understanding of CCPB emerged from a two stage process of interpretation. That is, they engaged in an internal process of first

communicating with themselves as to what CCPB meant for them and then transformed that meaning with reference to the context (patients, their workplace and experience) and acted accordingly. Being able to take the perspective of others is central to the idea of symbolic interactionism and CCPB. In addition, reflection forms a central role in nursing practice, both for pre-registration students and for qualified practitioners (Bulman et al. 2012). The NMC Code (2015) specifically requires nurses to engage in reflection on practice in order to improve performance and enhance practice. The participants in this study demonstrated reflection in, on, and after interaction with patients from diverse backgrounds. The meaning of CCPB was informed by these reflections within the context of professional and organisational socialisation in the clinical environment in which they worked.

Thus, as NQNs developed both personally and professionally their perceptions of CCPB changed because it was informed by, influenced and mediated by external, environmental, professional and organisational reference points. This interactivity influenced and shaped the meaning of CCPB (Charon 2010) and was consistent with Blumer's tenet (1962, 1969) that '*the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows'*. The words that participants used, the descriptions they provided were part of the socialisation process, the shared language and understanding created by and within communities (Charon 2010).

By approaching the data analysis with a focus on the language as advocated by proponents of symbolic interaction, I was able to surface important nuances in the words they chose to use and the changes that occurred, applying knowledge of the literature and understanding to the interpretation and discussion of these changes.

7.6.4 Understanding the study findings within the context of the NQNs 'journey' and the theoretical perspective (DMIS)

The notion of the 'journey' from novice to autonomous practitioner was used to assist understanding of the experiences of NQNs in this study. One of the challenges with research into transition was that it inevitably captures the transition experiences of the NQNs at a particular point in time. The journey had a clearly defined starting point (post registration and commencing employment) and the framework proposed for this study reflected previous research in the field examining the transition period.

I had chosen to focus on this particular time point as I have considered this a period of intensive learning and development for NQNs and was based on my own experiences of supporting student nurses into the workplace. As the study progressed, further research emerged that supported this. The first six months of practice were not just important for developing competence but more important than the following six to twelve month period (Lima et al. 2016). Reflecting on the journey, my initial insights were supported and in addition, it reinforced my opinion regarding traditional models of transition.

Whilst the models may have some applicability to current NQNs, the evidence that underpins them is based on the experiences of nurses in education and employment in the 1970's, 80's and 90's. These models remain unlikely to fully explain the experiences of contemporary NQNs as the healthcare landscape and nursing practice has changed significantly and continues to change.

However, whilst the timeframes within these models of transition may require a reconsideration, some of the stages previously described continue to have relevance. The first stage (induction and orientation into the workplace) appeared to be the most tumultuous for NQNs and their experiences during this time add support to, and are consistent with other work in the field of transition. The support seeking behaviours discussed in Section 6.2.2 would indicate that although formal mechanisms for support did not appear to be in place this was being provided informally and by the wider MDT.

In the second stage (period of supervised practice 0-6), NQNs perceptions of their confidence and competence and nursing practice continued to draw parallels with other work in the field, although were in opposition to Andersson and Edberg's (2010) conceptualisation of still being a "rookie" at this stage. The NQNs in this study also appeared to be beyond Benner's (1984) novice and advanced beginner stage. Given that accelerated learning occurs more so in the first 6 months (Lima et al. 2016), the NQNs in this study appeared to be already nearing the competent stage (Benner 1984).

In the original model, it was proposed that NQNs would be competent and confident practitioners between six and nine months (allowing for some individual differences). The interviews were scheduled for all participants between eight and nine months into practice to capture this. Duchscher (2008) refers to NQNs as 'knowing' in this stage and 'knowing' was equally evident in the directed reflections provided at five months. As with the earlier stage, Dearmun (2000)'s model appeared most relevant to the experiences of the NQNs in this study as they ready for new developments, learning and opportunities to progress. Evans (2001) had suggested that integration into the profession takes place as NQNs come towards the end of their first year. Although this study did not collect data at the twelve month point, the findings from this study would challenge Evans's (2001) assertion. It appeared that for the NQNs in this study, integration (professional and occupational socialisation) was evident much earlier in the timeframe. Andersson and Edberg 's (2010) view that this stage involved becoming a genuine nurse, and most of the participants clearly identified with the role of nurse at the five and eight month time points.

As the idea of 'the journey' used in this study was based on previous and earlier work on transition it represented a synthesis of several studies and models. The seminal work of Benner (1984) was acknowledged as well as Meleis et al.'s (2000) middle-range theory of experiencing transitions. One of the strengths of the Meleis et al.'s (2000) model was the insight it provided into process indicators (feeling connected, interacting, location and being situated, developing confidence and coping) and these did have particular

value in my interpretation of the study findings. Whilst difference studies and models were examined to inform this research, these were variably useful in terms of application to the NQNs in this study. The first stage of all of these models would appear to be the most relevant to understanding the experiences of NQNs. Kramer's 'culture shock' (Kramer 1974) and Duchscher's (2009) 'transition shock' continue to have significance and applicability to the experiences of NQN in this study. There does however, appear to be a need for a revisiting of contemporary models of transition. One of the key limitations with these models is that they fail to separate out key constructs relevant to understanding the experiences of NQNs. Models like Benner's (1984) are focused on perceived competency levels, whilst others (Evans 2001, Anderson and Edberg 2010) explored personal identity as a nurse and Dearnum (2000) focused on stages relevant to understanding professional and organisational socialisation.

The theoretical model used in this study was the Developmental Model of Intercultural Sensitivity (DMIS) (Bennett, 1986; 1993; 2009) and this was also illustrative of a journey. As discussed in Section 4.5.2, theoretically the NQNs in this study would engage in direct clinical experiences or 'cultural encounters' and this would embed knowledge and skill (Ingram 2012). Movement along the continuum was proposed and was linked to the notion of accelerated learning during the first six to nine months. As participants had not completed the IDI, the opportunity to explore this within the interviews was not possible. Notwithstanding this potential limitation, interpretation of participant responses were reflected on with reference to the DMIS. It was

evident that participants started their journey at slightly different starting points.

The directed reflections provided at two-three months into the study could be seen as examples of the NQNs generally operating within the ethno-centric part of the continuum. Some participants appeared to be situated in the ‘defence against difference stage’ (stage 2), however, directed reflections at this stage indicated that the majority were in the ‘minimisation of difference stage’ (stage 3). Although this is associated with a superficial understanding of cultural differences, this would appear to be consistent with the other research indicating levels of cultural competence immediately post qualification (see Section 2.5.2). In this stage, people tend to consider themselves tolerant and accepting of others, however are not necessary aware of their own privileged position.

None of the participants could be described as residing in the ‘denial of difference stage’ (stage 1), however, this is probably accounted for by the fact that they had actively engaged in a study on cultural competence and thus could not be described as uninterested in cultural differences. As NQNs progressed they were examples of participants expressly attempting to be more accepting of difference (stage 4) and thus moving from what Bennett (1986, 1993) described as from either ‘defense to minimisation’ or from ‘minimisation to acceptance’. This was illustrated by participants’ ability to

recognise, appreciate and be respectful of the existence of culturally different ways even when they did not necessarily like or agree with them.

However as noted earlier in the discussion, participant perceptions of CCPB although initially focused on difference became more focused on sameness and this may well indicate that that progression through to the ethno-relative stages did not occur. Bennett (1986, 1993) anticipated that movement through the stages might not be unidirectional. In addition, movement through these stages may require direction and further learning and as the IDI was not completed, participant did not take advantage of this opportunity to develop.

At the start of this thesis it was hypothesised that an increase in cultural 'encounters' and experiences of cultural diversity within the healthcare environment would facilitate progression through the stages. The literature on cultural immersion would suggest that this was a valid assumption to make. There was an expectation that the direction of travel for participants would be in a positive direction. Whilst there was some evidence from analysis of the findings to suggest that with increased competence and confidence NQNs are able to move along the continuum but this cannot be established as a causal relationship without further research. The direction of expected movement along the continuum can be facilitated by supportive working environments which enhance competence and confidence.

7.7 The limitations of this study

Having discussed the key findings and provided an account of interpretation of these within the context of existing literature and the methodological and theoretical frameworks, the study limitations will now be addressed.

This study was developed and conducted using robust methods informed by a particular perspective; the methodological and philosophical lens. This research was positioned ontologically as recognising that meaning regarding the topic was seen as constructed by people as they interacted, engaged with and interpreted the world in which they were situated (Crotty, 2003). It may well be that a group of NQNs in a different time or location may have responded to the questions differently generating alternative interpretations of CCPB. This limitation would be equally applicable to any study premised on similar assumptions. Indeed it was acknowledged earlier that all research exploring transition takes place in a particular point in time and this may account for why some models of transition did not appear applicable to the NQNs in this study. However, many of the key themes and ideas that emerged from the data were supported by other evidence in the field and adding to the potential transferability of the findings (Pringle et al. 2009).

This study was not attempting to generalise the findings to a larger population but to provide a narrative that created associations between the participant accounts of their practice and general theories and frameworks.

The sample recruited to the study comprised 14 people, however each participant provided three sets of data (two directed reflections and one interview) totalling 42 data sources increasing the likelihood of data saturation (Mason 2010). However, time limited studies (as in a PhD) and availability of participants (see challenges with recruitment, Section 5.5.1) placed a constraint on any further data collection (Strauss and Corbin 1990).

Although no new concepts were emerging in analysis, additional participants and data may have altered the emphasis. In addition, a modified version of the diary method was used (Bartlett and Milligan 2015) informed by a fixed schedule or time modeled approach advocated by Bolger et al. (2003). This may have compromised the integrity of the approach and the study findings as data captured continuously may have provided different accounts. Given that this was stated as a potential criticism of other studies, this limitation equally applies to this study. However, the potential for participant burden was a qualifying factor in this decision.

In addition, all participants were recruited from three HEI's in the North of England which represented a limited geographical area. The experiences of NQNs may be unique to this particular location in terms of their educational preparation. Notwithstanding this, it should be noted that all pre-registration nursing programmes in the UK are all approved by the NMC and all potential registrants must meet the relevant standards and competencies (NMC, 2010). The NMC (2014) Standards for competence for registered nurses

specifically emphasise and acknowledge the importance of competency in relation to culturally sensitive care delivery. All the participants in the study irrespective of the location of their education preparation, they will have achieved a standardised minimal level of competency. It is acknowledged however that there are considerable differences between programme content and delivery of cultural competence (Horvat et al. 2014).

In relation to the study sample, the personal backgrounds and diversity of the participants may also have impacted upon the findings. 8 participants were White British and 5 specifically identified themselves as from a BAME background. This personal history, upbringing and culture may have increased their cultural sensitivity (Chang et al. 2013). Personal experiences of diversity were seen by participants as important to understanding of experiences of diverse patients. The student population in HEI (1) was substantially more diverse than in the other two HEI's and of the 9 participants recruited from this HEI, 4 were from a BAME background reflecting the diversity of the population in the geographical location. Consequently, experiences interacting with people from diverse backgrounds (both within and without of healthcare settings) was more likely to occur for HEI (1) students. Thus the participants recruited from HEI 1 may have increased personal diversity as well as increased exposure to caring for patients from diverse backgrounds.

In relation to transition, participants were working primarily in NHS settings although in different geographical locations as well as different clinical environments. Thus, the experiences provided were not specific to a specific clinical or provider context and can be seen to represent transition generally across a range of contexts rather than specifically focusing on one clinical setting.

The accounts were however mainly generated with reference to NHS contexts and the transition of NQNs in non-NHS settings may be considerably different. The participant who worked in a private setting did indeed appear to experience a less demanding care environment in terms of workload pressures and constraints. As the purpose of the study was to explore the perceptions of culturally competent practice behaviour by NQNs, their perceptions have relevance irrespective of physical location of the participants or programme of study.

This study chose to focus on NQNs rather than student nurses or ‘experts’, however, they were evidently anxious and overwhelmed at this particular time point as consequently data gathered in the earliest stage was focused on their own concerns. In addition, data captured at pre-qualification may have provided an additional insight into the journey experienced by NQNs. Using a purposive volunteer or convenience sample can impact on the diversity of the study sample. The participants were however, broadly

representative of the nursing workforce in terms of gender and ethnicity (NMC 2016).

However, the diversity in the study sample may well be because of the nature of the topic area that attracted participants from diverse backgrounds. The participants in the study were predominantly qualified Adult Nurses, and as this was a volunteer sample (with some recruitment difficulties) it was not possible to include additional participants or those with other qualifications within the timeframe imposed by data collection. However, this does limit perhaps the applicability of the study findings to other fields of practice as they may well have additional, field specific issues to consider in relation to CCPB.

Age of participants was not captured and this may have affected the study findings as there is some evidence to suggest that older more experienced students may have managed the transition differently and they had have more life experiences including interaction with diverse people. With a quantitative study, age would be a necessary variable to capture to explore variance and individual differences and it is not possible to state whether age might have accounted for outliers or alternative viewpoints.

A volunteer sample was chosen for this study and it is likely that NQNs who were interested in the topic area chose to take part. Indeed the purpose of the study was to include those with an interest in the topic. A limitation of this

study might be that an alternative (non-volunteer) sample may have generated more alternative and comparative perspectives in relation to some of the key findings.

The methods used and measurement tools may have also limited this study. The reflective templates developed for participants were directive in terms of what was asked (See appendix 4). This may well account for the fact that the examples provided by NQNs at the start of the study were focused on diversity specific characteristics. The generalising momentum identified in the findings, did however begin to surface during the second stage when the (same) directed reflection was completed. Therefore this change in language and terminology cannot be accounted for solely by the directed reflection. The directed reflections aimed to surface rich descriptors of CCPB which could be further explored in the interviews and they were not always completed in sufficient detail by participants. It might be that using the repeated interview format or the full diary approach may have generated additional context, data and exemplars. In addition, as interviews were conducted over the telephone, rather than face to face this may have compromised the quality of the data. The strengths and limitations of the telephone interview was discussed in Section 4.7.2.

The approach taken to reviewing the literature may have also had an impact on subsequent interpretation of the findings. As previously noted, there was considerable literature (including systematic evidence reviews) in relation to

transition and NQNs, and on interventions to enhance cultural competence in health care professionals. Rather than replicate existing research in the field a methodological decision was made (Hart 1998) to focus on a combined search strategy to identify studies relevant to CCPB and NQNs. The lack of available evidence in relation to this combined focus provided justification in support of the study as it demonstrated the need for further research. The search strategy was adhered to but the application of inclusion and exclusion criteria resulted in the removal of a number of papers, particularly those that did not provide information regarding skills, behaviours and, or competencies. Although this was justified as the focus was on CCPBs, an alternative and, or supplementary search using a concept mapping approach (as used by Cai 2016) focused exclusively on cultural competence models may have identified relevant information to CCBP although not necessary primary research. Whilst IR methods facilitate the inclusion of a range of different methodologies and is advocated in nursing research, there are limitations that can undermine rigour and accuracy (Whittemore and Knafl 2005).

As each paper was reviewed by the researcher, this may have resulted in bias in the selection.

7.8 Conclusion

The findings from this study have provided some unique insights into the experiences of NQNs into CCPB during the first nine months of professional practice. It was evident that the early experiences caring for and interacting with patients from diverse backgrounds, informed and shaped participant perceptions. Delivering culturally appropriate care to patients during the first few months of transition was compromised by self-perceived deficits in knowledge and practice skills. This applied to nursing care generally as well as specifically to patients from diverse background. Professional and organisational socialisation within the workplace appeared to facilitate the development of NQNs and they assimilated new and novel experiences. As self-perceived competence and confidence increased, perceptions of CCPBs changed. Descriptions of their actions and practice were consistent with the language found in the NMC Code (2015) and Standards for Competence for Registered Nurses (NMC 2014).

Although this study has demonstrated some unique insights into NQNs perceptions of CCPB, it has also served to emphasise existing difficulties within this area of practice. NQNs struggled to conceptualise CCPB in concrete terms (or as discreet behavioural descriptors) possibly because of conceptual ambiguity and the constant evolving and changing of the construct. The assumption that NQNs should and could be culturally competent upon qualification must be called into question and a more

informed understanding of what qualities and skills they require at the point of registration is required.

Despite challenges in articulating CCPB, one particular skill emerged as core to this area of professional practice; communication. The importance of communication skills was central to participant accounts throughout all three stages. Skilled communication with patients from diverse backgrounds was seen as essential for ensuring patient trust and was applicable to all patients. As discussed by Gorgi (2009), if you cannot imagine the phenomena without a particular characteristic, then it is likely that this characteristic is ‘essential’ or ‘core’.

Chapter 8: Study contribution to the field and recommendations

8.1 Introduction

In this final section of the thesis, the study aim, objectives and research questions are revisited in light of the study findings and brief summaries are provided. The strengths of this study and its contribution to the body of knowledge in the field will then be discussed. The dissemination activities undertaken to date to promote the study findings and generate future impact are also highlighted. This will be followed by recommendations for nurse education, nursing practice and research based on the findings and the broader literature to inform further development of the knowledge and practice base in this field.

8.2 Revisiting the study aim, objectives and research questions

The primary aim of this PhD thesis was to explore the perceptions of culturally competent practice behaviour by NQNs.

Objective 1: To explore with NQN's their experiences and perceptions of caring for patients from diverse backgrounds

1. What are NQNs experiences of engaging with patients from diverse backgrounds following registration and commencement of employment?
2. Have NQNs developed the skills and competencies to care for culturally diverse patients?

The NQNs in this study had experience caring for and interacting with patients from diverse backgrounds throughout their involvement in this study. These experiences informed their perceptions of CCPB and as their self-perceived competence and confidence increased, their perceptions of CCPB changed. Perceptions of CCPB was perceived initially by NQNs as comprising diversity specific actions or behaviours that they undertook in response to the perceived diversity characteristics of the patient. Their primary concern during the earlier stages of the transition was on their own competence and confidence (or lack thereof). As NQNs developed both personally and professionally they were able to develop specific skills and competencies in order to care for culturally diverse patients. The behaviours they described were consistent with core nursing competencies and values evident in the NMC Code (2015).

Objective 2: To explore with NQNs their perceptions of the skills, competencies and behaviours that constituted CCPB

3. Does NQNs cultural competence change (increase, decrease or stay the same) as they undergo the transition from novice to autonomous practitioner?
4. What are the skills and competencies of culturally competent practice behaviour?

In relation to skills, behaviours and competencies, communication was cited as the most important skill that participants associated with CCPB. Communication skills were initially considered in terms of the challenges they experienced particularly in relation to language barriers, but as confidence and competence increased they were able to detail a range of communication approaches used in practice. Communication remained a persistent theme throughout the transition period and was increasing linked to the importance of ensuring patient trust as well as responding to diversity specific communication needs. By the conclusion of the study, NQNs considered themselves competence and confident to deliver care to all patients irrespective of background. They recognised that learning and developing their practice was an on-going activity and remained committed to enhancing their skills.

Objective 3: To explore (self-perceived) factors that enable or facilitate, limit or hinder the development of cultural competent practice behaviour as NQNs undergo transition

5. What (self-perceived) factors enable or facilitate the development of culturally competence practice behaviours as they undergo the transition from novice to autonomous practitioner?
6. What (self-perceived) factors or limit or hinder the development of culturally competence practice behaviours as they undergo the transition from novice to autonomous practitioner?

The role of others in the workplace was seen as especially important in the first few months of practice as NQNs integrated into the new workplace environment. The earlier stages were characterised by feelings of uncertainty and anxiety and support seeking behaviours were common. Participants recognised and acknowledged their limits and sought to remedy their self-perceived deficits in knowledge and practice skills. A positive and supportive workplace culture was important to NQNs to ensure that they were able to learn from others and accommodate new experiences. Equally, increased exposure to and experience of patients from diverse backgrounds enhanced skills and confidence in relation to communication, pre-planning care and meeting patient needs. Personal experiences of being diverse were seen as important in providing insight into, and understanding of patient preferences and needs.

Workload pressures, limited resources and time constraints were seen as having a significant impact on the NQNs capacity to deliver care within healthcare settings. This was applicable to care delivery generally as well as

specifically in relation to patients from diverse backgrounds. At an individual level, personal diversity could have a potentially negative impact for NQNs in terms of their relationships with patients, families and carers.

8.3 Study strengths and contribution to the body of knowledge

Undertaking research is of great importance to the profession of nursing in order to understand, document and demonstrate the value and benefit of nursing practice (Ditomassi et al. 2016). There are a number of aspects of this study which are unique and constitute a contribution to the knowledge and practice base in nursing.

This study has provided a contemporary and unique perspective on an area of important professional nursing practice; that of culturally competent practice behaviour. Whilst other studies in the field have explored the experiences of NQNs during the transition period or the cultural competence of qualified nurses, this study is unique in combining these two subject matters. Previous research into cultural competence has focused primarily on the experiences of student nurses or, on qualified and experienced nurses rather than NQNs in transition. As NQNs enter the workplace, knowledge and practice skills developed during education and training are enhanced and embedded as they transition to fully accountable practitioners. One of the strengths of this study is its focus on this period of development as a

distinctive point in time in which to examine personal and professional competency.

Having recently completed a pre-registration nursing programme, NQNs have benefited from education that presented a contemporary perspective of cultural competence. NQNs are thus a unique and particularly relevant group to study in relation to this topic area in order to understand CCPB within the context of today's nursing practice and healthcare context. This study has therefore provided a contemporary understanding of CCPB within this group of nurses.

This study sought to move beyond the current professional and regulatory statements which remain predominantly prescriptive to a more informed understanding of CCPB grounded in the real world experiences and understanding of NQNs. The study findings have consequently built upon existing work in this field, adding to the knowledge base and contributing to the on-going debate regarding the skills, behaviours and competencies of CCPB. The study generated tangible practice focused examples of the delivery of CCPB.

The data generated from this study indicated that from the perspective of NQNs, communication (both general communication and cross-cultural communication) are pivotal to providing care to patients from diverse backgrounds. These findings lend additional weight to the work of other

authors in the field as to the centrality of communication to this area of practice. However, I have argued that communication is the core connecting skill that links the other domains found within cultural competence models. As communication underpins all interactions with patients, this is not just an important skill, I would argue it was the skill of CCPB. Therefore this study has provided a significant contribution to the debate on CCPB and has sought to distinguish between generic and diversity specific actions or behaviours.

The skills and competencies of graduate nurses as they enter professional healthcare practice remains under scrutiny in the post Francis era (NHS England 2016b). This study represents a timely inquiry into CCPB within the context of the wider debate within the UK NHS on the need to deliver compassionate, dignified and respectful care. The future generation of nurses are required to deliver care to a diverse and ever changing patient population and this study has facilitated understanding of an area of focus for skill development and enhancement for education and practice providers within nursing. As the current pre-registration standards for nursing in the UK are under review, the findings from this study are timely in illustrating the importance and centrality of communication.

Finally, whilst the primary focus of this study was not transition per se, this study has provided important insights into the general transition experiences of NQNs. Rather than a purely retrospective account of the transition

experience, this study has captured NQNs at repeated intervals to inform understanding of process as well as outcome. One of the strengths of this study has been that the design captured change and development in NQNs, rather than a retrospective account of transition. It has also contributed to a re-examination of existing models of transition informed by the experience of today's NQNs in the rapidly changing and constantly evolving healthcare landscape. This has informed an understanding of transition that has argued for a refocusing of traditional transition models to take into account relevant organisational factors including team based approaches to NQNs support and socialisation.

8.4 Dissemination and impact of the study to date

Widespread communication of the study findings via academic and professional networks has already been undertaken and this will continue via publication and presentation to generate impact. The work that was undertaken as part of the pilot study has already been published; Wray J, Archibong U and Walton S (2016) Why undertake pilot work in a qualitative PhD study? Lessons learnt to promote success. *Nurse Researcher*. 24 (3) 31-35 http://journals.rcni.com/doi/10.7748/nr.2017.e1416)

Additional papers are in preparation that will specifically focus on disseminating the study methodology and key study findings. The following papers are planned for 2017/8;

- Wray J, Archibong U and Walton S – the use of directed reflections and diary method to generate qualitative data. International Journal of Qualitative Methods.
- Wray J, Archibong U and Walton S – Culturally Competent Nursing Practice and Newly Qualified Nurses. Journal of Advanced Nursing

In addition, I have been approached by;

- The Journal of Nursing Management (RCN Publishers) to prepare a CPD paper on Organisational Support, Cultural Competence and NQNs based on my study findings.
- BMJ Blogs (Evidence Based Nursing) to do a blog on NQNs and transition.

The work undertaken as part of this PhD has already been shared with national and international audiences via relevant professional and academic conference presentations. These have included;

Wray J (2017) Newly Qualified Nurses' (NQNs) perceptions of culturally competent practice. The RCN Annual International Nursing Research Conference 2017 5th – 7th April Oxford

Wray J (2016) Developing a structured diary as a source of qualitative data: value, benefits and methodological challenges. The 2016 International Institute for Qualitative Methods (IIQM) Conference 2nd – 5th May Glasgow

Wray J (2016) The value of using a structured diary as a source of qualitative data: value, benefits and methodological challenges. FHSC Research Seminar, University of Hull 21st April, Hull

Wray J (2015) Why undertake pilot work in a qualitative PhD study? Lessons learnt to promote success RCN Annual International Nursing Research Conference and Exhibition 20 – 22 April Nottingham

Wray J (2015) Perceptions of culturally competent practice behaviour: some preliminary reflections from a PhD study 5th International Making Diversity Interventions Count Annual Conference (MDICAC) 16th June Bradford

Wray J (2013) Cultural competence and educational preparation of the nursing workforce" 3rd International Making Diversity Interventions Count Annual Conference (MDICAC) 18th June Bradford

These outputs have also been shared within the community of PGR students in the School of Health Sciences at Bradford University to both elicit feedback

and enhance impact within a wider academic network. In addition, linked with these key presentations, blogs have been completed and shared via webpages and social media platforms to further expand the public profile of my work.

In addition to specific presentations and papers, the knowledge and understanding of cultural competence gained as part of this PhD has been used to input directly into practice development within the nursing profession. This has included sitting on the Royal College of Nursing's (RCN) National Equality and Diversity Committee (2013-5) to provide specific insights into cultural competence in relation to education and workforce issues. A consequence of this work has been involvement in the production of specific guidance from the RCN 'Fair Care for Trans Patients Guidance' (https://www.rcn.org.uk/professional-development/publications/pub-005575)

As this study also explored NQNs and their experiences of transition into employment, the findings from the study were used to inform a successful funding bid to The Burdett Trust for Nursing. I am co-applicant and part of a research team in the School of Health and Social Work (SHSW), Hull University who were awarded £183,857 for a project "Supporting Transition and Retention" of newly registered nurses (STaR Project). This study will work directly with final year nursing students and prospective employers to prepare and plan for successful transition into the workplace. This three year project is due to commence in May 2017.

The experiences of the NQNs in this study provided valuable insights into current working experiences within the health sector. As a consequence of this, I have successfully secured £6000 (as co-applicant) to undertake a qualitative study to capture the stories of approximately 25 healthcare workers of international origin who have migrated to Hull and the surrounding areas to work. This study will form part of the University of Hull's engagement work for Hull City of Culture 2017 and the study will make these stories publicly accessible using a range of media and will acknowledge and celebrate the contribution of healthcare workers of international origin to the health and wellbeing of Hull and surrounding areas.

The findings from this PhD will be disseminated and communicated via academic and professional networks to create on-going impact and generate future developmental activity.

8.4 Recommendations

This final section will focus on the recommendations generated from this study and are sub-divided into the following key areas; nurse education, nursing practice and nursing research. These recommendations are primarily focused on the UK nursing profession and supported by a brief rationale based on the study findings. However, these recommendations are relevant to an international audience as well as other healthcare professional groups engaged in understanding CCPB in nursing.

8.4.1 Recommendation for Nurse Educators

Recommendation 1: The teaching of cultural competence

The teaching of CCPB at pre-registration level should focus on ensuring that student nurses are able to develop the skills consistent with cultural humility and motivation, awareness and this should be taught as relevant to all patient backgrounds rather than applicable to specific individuals or groups. Importantly, pre-registration nurses need to be provided with opportunities to explore their own backgrounds, bias and prejudices so that they are fully cognisant of the impact of these when interacting with patients. In the UK, the teaching of cultural competence should be linked directly to the values and behaviours in the NMC Code (2015), focused on illustrating the relationship and connectivity between the two. Competence should be assessed in practice by a suitably qualified mentor with a written reflection or assignment as an adjunct to this. Cultural humility with its emphasis on self-awareness, openness, self-reflection and critique (Foronda et al. 2015) would lend itself well to the pre-registration level offering a more substantive exploration of self in relation to CCPB and underpinning further skill and competency development post qualification.

Rationale: Understanding of cultural competence, its core domains and its application to nursing practice by NQNs in this study was often superficial, lacking insight into the meaning of valuing difference and with limited understanding of the impact of their own background, culture or context on

their interactions with patients. NQNs at the point of qualification need to be sensitive and aware of the impact of their own cultural perspective in terms of delivering health care as well as that of their patients. This should be taught and explained within the context of individualised patient care so that the culture can be understood as relevant to all patients rather than focused on specific cultural groups. Curriculum developers tasked with the development of new programmes in the UK to reflect the revised outcome focused standards for the new pre-registration standards for nursing need to consider how these outcomes are inclusive of the values set out in the Code (NMC 2015) and provide demonstrable outcomes in relation to CCPB that bridge theory and practice.

Recommendation 2: Communication skills

Communication competency and specifically cross-cultural communication skills should form a more substantive part of assessment competencies in pre-qualifying programmes and be consistent across fields of practice and educational providers. Linked to cultural awareness and sensitivity development, communication training should specifically include a more nuanced understanding of the communication encounter and the impact of this on the patient experience. In addition, specific skills are needed in providing care and support when there is no shared language proficiency between nurse and patient and managing challenging communication encounters. Advanced communication skills should be an integral part of the

transition planning, education and induction so that core skills can be built upon and developed.

Rationale: One of the key challenges identified by the NQN's in this study related to the significant anxiety and stress they experienced when language proficiency was not shared between nurse and patient. This was particularly acute in the early post qualification stage and therefore this should be addressed both at pre-qualifying levels and immediately upon entering the workplace. Communication and cross-cultural communication was seen as a key competency in relation to patients, families and also the wider MDT throughout the transition period. Advanced skills in cross-cultural communication should be also available for all staff undertaking supervisory or preceptorship roles within the workplace.

8.4.2 Recommendations for Nursing Practice

Recommendation 1: Transition Management and Workforce development

NQNs need to be supported as they transition into the workplace particularly during the first three to six months post qualification. In the UK, the model of preceptorship based on a one-to-one support approach needs to be reconsidered and alternatives investigated such as facilitated group or peer support. These models appear to better reflect contemporary practice and workforce settings. A multi-component model of transition should be

developed which is informed by the experiences of the individual nurse in terms of three core areas; role socialisation (identity), care delivery (developmental competencies) and organisational acclimatisation (environment / context). Generated collaboratively between nurses, employers and education providers, the model will represent an agreed way forward that addresses the transition needs or individual nurses and their employing organisations. Rather than a 'one size fits all approach', the model should explore how the individual intersects with the environment and tailor support to meet the individual nurse.

Rationale: The first few months of practice (up to six months) appear the most significant in terms of building competence and confidence particularly in relation to caring for patients from diverse backgrounds. It is during this time that professional and organisational socialisation occurs and it critical in ensuring that NQNs are positively supported by their peers and the organisation to develop the skills and behaviours that are consistent with the NMC Code (2015). Team working and collaboration reflect contemporary working practices in healthcare and sourcing support from across the organisation and different professional groups will provide additional opportunities for the NQN.

Recommendation 2: Facilitating CCPB post qualification

Post qualification education should be directly related to and build on pre-registration level awareness, knowledge and understanding. NQNs skills and competencies in relation to CCPB and particularly cross-cultural communication should form a discreet component of post qualification support and development during transition and workplace induction. As with recommendation 1, group or peer support should facilitate skill training and include discussion on CCPB, culturally sensitive issues and cross-cultural communication without of the pressure of the immediate work environment or clinical setting.

Rationale: The expectation that NQNs should be able to demonstrate CCPB upon qualification should be reconsidered. The evidence would appear to suggest that this may not be the case for the majority of nurses and by perpetuating this expectation we continue to add pressure to NQNs as they engage in transition. In accordance with Gallagher and Polanin's (2015) meta-analysis of educational interventions to enhance CCPB, specialised education and training in CCPB should be aimed at qualified rather that student nurses. This would build on the learning undertaken at pre-registration levels in which the foundation values of CCPB (cultural humility and motivation, awareness and sensitivity) were established.

Recommendation 3: The NMC Code (2015)

Both CCPB and the NMC Code (2015) have values in common which would benefit from additional work to make explicit these values and differentiate clearly professional values, expected behaviours and competencies. The ANA Code of Ethics provides a good practice model for the NMC, as this is published alongside interpretive statements that illustrate its application to real world nursing practice.

Rationale: Some of the statements in the NMC Code (2015) relevant to understanding the care or people from diverse backgrounds tend to be non-specific and open to individual interpretation. The NQNs tended to use this language when describing their care and did not always appear to fully comprehend the meaning of valuing difference. They had limited understanding of the impact of their own background, culture or context on their interactions with patients. Interpretive statements would facilitate a better understanding of the meaning behind the language of the NMC Code (2015) and its application to practice. The NMC (2014) Standards for competence for registered nurses have provided some additional information for NQNs regarding professional values and practice and in particular the field (branch) specific standards.

8.4.3 Recommendations for Nursing Research

Recommendation 1: Defining CCPB

There is an urgent need for some operational clarity regarding the term CCPB that is inclusive of a more contemporary patient and person centered perspective. In order to develop the knowledge and evidence base for this area of practice, further research is needed to develop a revised and agreed working definition of CCPB and operationalise the key elements via a consensual model of research. A multi-dimensional model should incorporate both the core constructs but connect and integrate this with an organisational context including the socialisation perspective. The concept mapping approach used by Cai (2016) and Foronda (2015) in conjunction with Numminen et al.'s (2015a) organisational focus would be helpful in providing direction for a revised model of CCPB.

Rationale: The term cultural competence has evolved and changed to encompass other terms and concepts that can be applied to individuals and, or organisations. For academics and researchers working in the area of cultural competence, it is evident that the meaning is CCPB is ambiguous and there is a lack of consensus as to which approach would best suit the UK perspective. Failure to provide clear definitions and to fully operationalise terms has compounded this confusion and served to further limit reliable measurement compromising the evidence base.

Recommendation 2: Patient perspectives and expectations

Further research is needed that specifically explores patient perspectives on CCPB and investigates their expectations as to what constitutes good practice. Specifically, patients and, or service users should be engaged to understand their perspective on the key salient features of CCPB as recipients of care. The active involvement of people as co-researchers and producers of knowledge could better provide an opportunity for patients, service users and the public to shape and direct the research agenda within this field of practice.

Rationale: The importance of the patient or service user voice to the research agenda within healthcare has been actively promoted and championed by nurses. The patient can provide a unique and important perspective on the nurses' skills, competencies and behaviours particularly in relation to communication and cross cultural communication. The absence of the patient perspective in the literature regarding CCPB has been acknowledged and this warrants further investigation. Equally, the role of patients as partners within research that seeks to improve or enhance CCPB of individual nurses and / or healthcare systems would provide unique insights into where future research might best focus to better meet the needs of patients.

7.4 Conclusion

This chapter has sought to illustrate the contribution of the study findings to the body of academic and professional knowledge in nursing that comprises CCPB. Whilst this study has already produced some outputs and impacts, the recommendations have identified where key stakeholder groups who might benefit from this work should focus further developmental work. These are concentrated in three key areas; nurse education, nursing practice and nursing research. They are interconnected and the recommendations for research will inform pre-qualifying education and nursing practice and vice versa. As the consultation on the new pre-registration nursing standards in the UK will commence in spring 2017, there is an opportunity for all qualified nurses and educational institutions to comment on these new standards.

In addition, whilst this study has a particular subject focus, the descriptors developed are relevant to the wider debate in the NHS on the erosion of values based care and the need for information and guidance on how best nurses can deliver the compassion, dignity and respect agenda (NHS England 2016b). Ambiguity as to what constitutes CCPB will continue to compromise research and practice in this field and importantly will impact upon the ability to demonstrate tangible outcomes for patients (Loftin et al 2013). Whilst the theoretical underpinning to CCPB is well established, there is a need for specific research that focuses on skills and behaviour required of nurses. The completion of this study is therefore timely and the planned dissemination of the study findings will continue to share with and influence the academic and practice community.

References

Adami, M.F. and Kiger, A. (2005) The use of triangulation for completeness purposes*. Nurse Researcher* 12 (4) 19-29

Abrams, L, and Moio, K. (2009) Critical race theory and the cultural competence dilemma in social work education. *Journal of Social Work Education* 45, 37-71

Adams JE and Gillman L (2017) Developing an evidence-based transition programme for graduate nurses. *Contemporary Nurse* 52(5), 511-521

Agee, J. (2009) Developing qualitative research questions: a reflective process, *International Journal of Qualitative Studies in Education* 22(4), 431-447

Ahmed, R, and Bates, B.R. (2012) Development of Scales to Assess Patients' Perceptions of Physicians' Cultural Competence in Health Care Interactions. *Journal of Transcultural Nursing* 23(3), 287-296

Alaszewski A (2006) *Using Diaries for Social Research.* London: Sage Publications

Ali, P. and Johnson, S, (2016) Speaking my patient's language: Bilingual nurses' perspective about provision of language concordant care to patients with limited English proficiency. *Journal of Advanced Nursing* 73(2), 421-432

Ali, S., Burns, C. and Grant, L. (2012) Equality and diversity in the health service: An evidence-led culture change. *Journal of Psychological Issues in Organizational Culture* 3(1), 41–60

Allan, S., Chapman, Y., O'Connor, M. and Francis, K. (2007) The Importance of Language for Nursing: Does It Convey Commonality of Meaning and Is It Important to Do So. *Australian Journal of Advanced Nursing* 24(4), 47-51

Allen, J. (2010) Improving cross cultural care and antiracism in nursing education: A literature review. *Nurse Education Today* 30, 314-320

Anderson, G. (2011) Students as valuable but vulnerable participants in research: getting the balance right using a feminist approach and focus group interviews. *Evidence Based Midwifery* 9 (1), 30-34

Andersson, L.P. and Edberg, K. (2010). The transition from rookie to genuine nurse: Narratives from Swedish nurse graduates 1 year after graduation, *Journal of Continuing Education in Nursing* 41(4), 186-192.

American Nurses Association (ANA) (2015) Code of Ethics for Nurses with Interpretative Statements. http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics-For-Nurses.html Accessed 21st January 2017

Arain, M., Campbell, M.J., Cooper, C.L. and Lancaster, G.A. (2010) What is a pilot or feasibility study? A review of current practice and editorial policy. *BMC Medical Research Methodology* 10, 67

Archibong, U., and Darr, A. (2010). *The involvement of Black and minority ethnic staff in NHS disciplinary proceedings*. University of Bradford, UK. ISBN 99781851432646.

Archibong, U., Baxter, C. E., Darr, A., Walton, S., and Jogi, M. (2013). Disciplinary and fitness-to-practice data, policies, and practices in the NHS trusts and health professional bodies in the UK. *Journal of Psychological Issues in Organizational Culture* 4(3), 6-25

Arnold, D.M., Burns, K.E., Adhikari, N.K., Kho, M.E., Meade, M.O. and Cook, D.J. (2009) The design and interpretation of pilot trials in clinical research in critical care. *Critical Care Medicine* 37(1), S69-74

Aronson, J., Burgess, D., Phelan, S.M. and Juarez, L. (2013) Unhealthy Interactions: The role of stereotype threat in health disparities. *American Journal of Public Health* 103(1), 50-56

Arthur, S., Mitchell, M., Lewis, J. and McNaughton Nicholls, C. (2014) Designing fieldwork. In Ritchie, J., Lewis J., McNaughton-Nicholls, C. and Ormston, R. (eds.) (2014). *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. 2nd Edition. London: Sage. 147-176.

Aveyard, H. (2010) *Doing a literature review in health and social care: a practical guide*. Maidenhead: Open University Press

Bainbridge, R., McCalman, J., Clifford, A. and Komla, T. (2015) *Cultural competency in the delivery of health services for Indigenous people. Issues paper no. 13 produced for the Closing the Gap Clearinghouse*. Canberra: Australian Institute of Health and Welfare and Melbourne: Australian Institute of Family Studies.

Balls, P. (2009) Phenomenology in nursing research: methodology, interviewing and transcribing. *Nursing Times* 105 (32), 30-33

Ballantyne H (2016) Developing nursing care plans. *Nursing Standard* 30(26), 51-57.

Banks, B., Roxburgh, M., Kane, H., Lauder, W., Jones, M., Kydd, A. and Atkinson, J. (2010). Flying Start™ easing the transition from student to registered health professional. *Journal of Clinical Nursing* 20 (23-24), 3567-3576

Barksdale, C.L., Rodick, W.H., Hopson, R., Kenyon, J. Green, K. and Jacobs, G.C (2017) Literature Review of the National CLAS Standards: Policy and Practical implications in Reducing Health Disparities. *Journal of Racial and Ethnic Health Disparities* 4 (4) pp 632–647

Bazeley, P. (2013) *Qualitative Data Analysis: Practical Strategies*. London: Sage

Bartlett, R. and Milligan, C. (2015) *What is the Diary Method?* London: Bloomsbury Academic (Bloomsbury Publishing PLC)

Beach MC, Price EG, Gary TL, Robinson K, Gozu A, Palacio A, Smarth C, Jenckes M, Feuerstein C, Bass EB, Powe NR, Cooper LA: Cultural competence: A systematic review of health care provider educational interventions. *Med Care* 43, 356–373.

Benner, P. (1984) *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. Menlo Park, CA: Addison-Wesley

Bennett, M. J. (2009) Defining, measuring and facilitating intercultural learning: A conceptual introduction to the Intercultural education double supplement. *Intercultural education,* 20(4) (supplement 1), 1-13.

Bennett, M. J. (2004). *Becoming interculturally competent*. In J.S. Wurzel (Ed.) Toward multiculturalism: A reader in multicultural education. Newton, MA: Intercultural Resource Corporation. (Originally published in The diversity symposium proceedings: An interim step toward a conceptual framework for the practice of diversity. Waltham, MA: Bentley College, 2002).

Bennett, M. J. (1993). Towards ethnorelativism: A developmental model of intercultural sensitivity (revised). In Paige R.M (Ed.), *Education for the Intercultural Experience.* Yarmouth, Me: Intercultural Press

Bennett, M. J. (1986). A developmental approach to training intercultural sensitivity. *International Journal of Intercultural Relations,* 2, 179-186

Benzies, K. M. and Allen, M. N, (2001) Symbolic interactionism as a theoretical perspective in multiple methods research. *Journal of Advanced Nursing* 33(4), 541-547

Berger, R. (2013) Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research* 15(2), 219–234

Berry, D.M. and Bass, C.P. (2012) Successfully recruiting, surveying and retaining college students: a description of methods for the Risk, Religiosity, and Emerging Adulthood Study. *Research in Nursing and Health* 35(6), 659-670

Betancourt, J.R., Green, A.R., Carillo, J.M. and Ananeh-Firempong, O. (2003) Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care. *Public Health Reports* 18, 293-302

Bhui, K., Warfa, N., Edonya, P., McKenzie, K. and Bhugra, D. (2007). Cultural Competence in mental health care: a review of model evaluations. *BMC Health Services Research* 7(15), 1-10

Blumer, H. (1969) *Symbolic Interactionism: Perspective and Method.* New Jersey: Prentice Hall

Bolger N, Davis A, Eshkol R (2003) Diary Methods: Capturing Life as it is Lived *Annual Review Psychology* 54, 579–616

Bray, L., O'Brien, M.R., Kirton, J., Zubairu, K. and Christiansen, A. (2014). The role of professional education in developing compassionate practitioners: A mixed methods study exploring the perceptions of health professionals and pre-registration students. *Nurse Education Today* 34(3), 480–486

Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* 3(2), 77-101

Bryman A (2012) *Social Research Methods* (4th Edition). Oxford: Oxford University Press

Brett, J., Staniszewska, S., Mockford, C., Herron-Marx, S., Hughes, J., Tysall, C., & Suleman, R. (2012). Mapping the impact of patient and public involvement on health and social care research: a systematic review. *Health Expectation*. doi: 10.1111/j.1369-7625.2012.00795.x

Byrne, G. and Heyman, R. (1997) Understanding nurses' communication with patients in accident and emergency departments using a symbolic interactionist perspective. *Journal of Advanced Nursing* 26, 93-100

Bubb, S. (2014) *Winterbourne View – Time for Change. Transforming the commissioning of services for people with learning disabilities and/or autism*. A report by the Transforming Care and Commissioning Steering Group

https://www.england.nhs.uk/wp-content/uploads/2014/11/transforming-commissioning-services.pdf Accessed 21st January 2017

Buchan, J., Seccombe, I. and Charlesworth, A. (2016) *Staffing matters; funding counts. Workforce profile and trends in the English NHS*. http://www.health.org.uk/publication/staffing-matters-funding-counts

Accessed 21st January 2017

Bulman, C., Lathlean, J. and Gobbi, M. (2012) The concept of reflection in nursing: qualitative findings on student and teacher perspectives. *Nurse Education Today* 32(5), 8-13

Burkard, A., Johnson, A.J., Madson, M.B., Pruitt, N. and Contresas-Tadych, D.A. (2006) Supervisor cultural responsiveness and unresponsiveness in cross cultural supervision. *Journal of Counseling Psychology* 5 (3), 288-301

Butterworth T. (2014) Onslaught of change (Board Editorial) The nursing profession and its leaders- hiding in plain sight? *Journal of Research in Nursing* 19 (7–8), 533–536

Calvillo, E., Clark, L., Ballantyne, J.E., Pacquiao, D., Purnell, L.D. and Villarruel, A.M. (2009) Cultural Competency in baccalaureate nursing and education. *Journal of Transcultural Nursing* 20 (2), 137-45

Cai, D.Y. (2016) A concept analysis of cultural competence. *International Journal of Nursing Sciences* 3, 268-273

Campinha- Bacote, J. (2002) The Process of Cultural Competence in the Delivery of Healthcare Services: A model of care. *Journal of Transcultural Nursing* 13(3), 181-184

Campinha-Bacote, J. (2011) Delivering Patient-Centered Care in the Midst of a Cultural Conflict: The Role of Cultural Competence OJIN: *The Online Journal of Issues in Nursing* 16 (2) Manuscript 5.

Carter, M., Thompson, N., Crampton, P., Morrow, G., Burford,B., Gray, C and Illing, J. (2013) Workplace bullying in the UK NHS: a questionnaire and interview study on prevalence, impact and barriers to reporting. *BMJ Open* 2013; 3:e002628.

Canales, M.K. and Bowers, B.J. (2001) Expanding conceptualizations for culturally competent care. *Journal of Advanced Nursing* 36(1),102-111

Carlson, E. (2013) Precepting and symbolic interactionism – a theoretical look at preceptorship during clinical supervision. *Journal of Advanced Nursing* 69(2), 457-464

Carr, E.C.J. and Worth, A. (2001) The use of telephone interview for research. *NT Research* 6(1), 511-25

Calvillo, E., Clark, L., Ballantyne, J.E., Pacquiao, D., Purnell, L.D. and Villarruel, A.M. (2009) Cultural Competency in baccalaureate nursing and education. *Journal of Transcultural Nursing* 20(2), 137-45

Centre for Reviews and Dissemination (CRD) (2008) *Systematic Reviews CRD's guidance for undertaking reviews in health care*. University of York available at https://www.york.ac.uk/media/crd/Systematic_Reviews.pdf Accessed 28th September 2014

Chang, H.Y., Yang, Y.M. and Kuo, Y.L. (2013) Cultural sensitivity and related factors among community health nurses.*Journal of Nursing Research* 21(1), 67-73

Charon, J.M. (2010) *Symbolic Interactionism: An introduction, An interpretation, An integration.* 10th Edition London: Prentice Hall

Clarke, E. and McCann, T. (2005) Researching students: an ethical dilemma. *Nurse Researcher* 12(3), 42-51

Clayton, A.M. and Thorne, T. (2000) Diary data enhancing rigour: analysis framework and verification tool. *Journal of Advanced Nursing* 32 (6), 1514-1521

Constantine, M.G. and Sue, D.W. (2007) Perceptions of Racial Microaggressions Among Black Supervisees in Cross-Racial Dyads. *Journal of Counseling Psychology* 54(2), 142-153

Cornwall, J. (2012) The care of frail older people with complex needs: time for a revolution. The Kings Fund. https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/the-care-of-frail-older-people-with-complex-needs-mar-2012.pdf Accessed 28th September 2014

Creswell, J.W. (1998) *Qualitative inquiry and research design. Choosing among five traditions*. London: Sage Publications

Creswell, JW and Miller DL (2000) Determining validity in qualitative inquiry *Theory into Practice*, 39(3), 124-131

Cruess, R.L., Cruess, S.R., Boudreau, J.D, Snell, L. and Steinert, Y. (2015) A Schematic Representation of the Professional Identity Formation and Socialization of Medical Students and Residents: A Guide for Medical Educators. *Academic Medicine*, 90(6) 718-725

Crocker, J.C., Boylan, A-M., Bostock, J. and Locock, L. (2016) Is it worth it? Patient and public views on the impact of their involvement in health research and its assessment: a UK-based qualitative interview study. *Health Expectations* 20(3), pp. 519–528 DOI: 10.1111/hex.12479

Crookes, P. and Davies, S. (1998). *Research into practice 3: essential skills for reading and applying research.* London: Royal College of Nursing

Cross TL, Bazron BJ, Dennis KW, Isaacs MR and Benjamin MP (1989) *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed*. National Criminal Justice Reference System (NCJ No 124939). https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=124939 Accessed 28th September 2014

Crotty, M. (2003) *The Foundations of Social Research: Meaning and Perspective in the Research Process,* 3rd Edition London: Sage Publications.

Cushner, K., McClelland, A., and Safford, P. (2012). *Human Diversity in Education.* New York: McGraw Hill.

Cubit, K.A. and Ryan, B. (2011) Tailoring a Graduate Nurse Programme to meet the needs of our next generation nurses. *Nurse Education Today* 31, 65-71

Currie, L. and Watts, C. (2012) *Preceptorship and pre-registration nurse education. Published by the Willis Commission*. Available at: http://www.williscommission.org.uk/__data/assets/pdf_file/0011/479936/Preceptorship_and_pre-registration_nurse_education.pdf Accessed 24th June 2015

Data Protection Act (1998) http://www.legislation.gov.uk/ukpga/1998/29/contents Accessed 21st January 2017

Dearmun, A.K. (2000) Supporting newly qualified staff nurses: The lecturer-practitioner contribution. *Journal of Nursing Management* 8(3), 159-165

Deasy, C., Doody, O. and Tuohy, D. (2011) An exploratory study of role transition from student to registered nurse (general, mental health and intellectual disability) in Ireland. *Nurse Education and Practice* 11(2), 109–13

Delaney, C. (2003) Walking a fine line: Graduate nurse' transition experiences during orientation, *Journal of Nursing Education* 42 (10), 437-443

Denzin, N. K and Lincoln, Y. S. (2000) The Discipline and Practice of Qualitative Research. In Denzin, N. K. and Lincoln, Y. S. (2000) (Eds.) *Handbook of Qualitative Research.* Thousand Oaks, CA, Sage Publications

Department of Health (2005) *Research governance framework for health and social care: second edition* https://www.gov.uk/government/publications/research-governance-framework-for-health-and-social-care-second-edition Accessed 5th May 2013

Department of Health (2009) *Tackling Health Inequalities: 10 Years On A review of developments in tackling health inequalities in England over the last 10 years*. Crown Copyright HMSO: London

Department of Health (2010a). *Equity and excellence: liberating the NHS*. Cm 7881. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf Accessed 20 September 2017.

Department of Health (2010b) *Preceptorship Framework for newly qualified nurses, midwives and allied health professionals.* London: Department of Health

Department of Health (2011) *Competency Framework for Equality and Diversity Leadership*. Published by NHS Northwest at www.help.northwest.nhs.uk/framework

Department of Health (2012) *Compassion in Practice - Nursing, Midwifery and Care Staff Our Vision and Strategy.* https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf Accessed 9th January 2017

Department of Health (2015) *The NHS Constitution for England*. HMSO Crown Copyright: London

Dickson-Swift, V., James, E.L., Kippen, S. and LaimPuttong, P. (2007) Doing sensitive research: what challenges do qualitative researchers face? *Qualitative Research* 7(3), 327-353

Dibley, L. (2011) Analysing narrative data using McCormacks Lenses. *Nurse Researcher* 18 (3), 13-19

Dinmohammadi M., Peyrovi H., and Mehrdad N (2013) Concept Analysis of Professional Socialization in Nursing. *Nursing Forum* 48, 26-34.

Ditomassi, M., Erickson, J.I. and Jones, D.A. (2016) Why research is vital. *Nursing Management* 23(1), 13-13

Doody, O., Tuohy, D and Deasy, C. (2012) Final-year student nurses' perceptions of role transition. *British Journal of Nursing*, 21(11), 684-8

Douglas, M.K., Rosenkoetter, M., Pacquiao, D.F., Callister, L.C., Hatter-pollara, M., Lauderdale, J., Milstead, J., Nardi, D. And Purnell, L. (2014) Guidelines for Implementing Culturally Competent Nursing Care. *Journal of Transcultural Nursing* 25(2), 109 –121

Doutrich, D., Arcus, K., Dekker, L. Spuck, J. and Pollock-Robinson, C. (2012) Cultural safety in New Zealand and the United States: looking at a way forward together. *Journal of Transcultural Nursing* 23(2), 143–50

Dowling, M. (2007) From Husserl to van Manen. A review of different phenomenological approaches. *International Journal of Nursing Studies*, 44(1), 131-142

Drake P (2010) Grasping at methodological understanding: a cautionary tale from insider research. *International Journal of Research and Method in Education* 33(1), 85–99

Draper, P.R., Wray, J. and Burley, S. (2013) Exploring Nurses' use of language with older people. *Nursing Older People* 25(9), 18-23

Dressel, J.L., Consoli, A.J., Kim, B.S.K. and Atkinson, D.R. (2007) Successful and Unsuccessful Multicultural Supervisory Behaviors: A Delphi Poll. *Journal of Multicultural Counseling and Development*, 35(1), 51–64

Duchscher, J.E.B. (2008) A process of becoming: The stages of new nurse graduate professional role transition. *Journal of Continuing Education in Nursing*, 39 (10), 441-450

Duchscher, J.E.B. (2009) Transition shock: the initial stage of role adaptation for newly graduated Registered Nurses. *Journal of Advanced Nursing* 65(5), 1103–1113.

Earle, V. (2010) Phenomenology as research method or substantive metaphysics? An overview of phenomenology's uses in nursing. *Nursing Philosophy* 11, 286-296

Easterby-Smith, M., Thorpe, R. And Lowe A.l. (1997) *Management Research: an Introduction*. London, Sage Publications

Economic and Social Research Council (2015) Framework for research ethics Updated January 2015. http://www.esrc.ac.uk/files/funding/guidance-for-applicants/esrc-framework-for-research-ethics-2015/ Accessed 9th January 2017

Edwards, D., Hawker, C., Carrier, J., and Rees, C. (2011). The effectiveness of strategies and interventions that aim to assist the transition from student to newly qualified nurse. *JBI Library of Systematic Reviews* 9(53), 2215–2323

Elmir R., Schmied V., Jackson D. and Wilkes L. (2011). Interviewing people about potentially sensitive topics. *Nurse Researcher* 19(1), 12–16

Elo, S. and Kyngas, H, (2008) The qualitative content analysis process *Journal of Advanced Nursing* 62 (1), 107–115

Endicott L, Bock T and Narvaez D (2003) Moral Reasoning, intercultural development and multi-cultural experiences: relations and cognitive underpinning International *Journal of Intercultural Relations,* 27, 403-419

The Equality Act (2010) Available at: http://www.legislation.gov.uk/ukpga/2010/15/contents Accessed 14th April 2017

Equality and Human Rights Commission (2010). *How fair is Britain? The first Triennial Review (Executive Summary).* Manchester: Equality and Human Rights Commission

Equality and Human Rights Commission (2012). Human Rights Review. How fair is Britain? An assessment of how well public authorities protect human rights. https://www.equalityhumanrights.com/en/publication-download/human-rights-review-2012 Accessed 28th January 2017

Equality and Human Rights Commission (2014). Equality Information and the Equality Duty: A Guide for Public Authorities England (and non-devolved public authorities in Scotland and Wales). https://www.equalityhumanrights.com/sites/default/files/equality_information_and_the_equality_duty.pdf Accessed 20th September 2017

Equality and Human Rights Commission (2015). Is Britain Fairer? The state of equality and human rights 2015.

https://www.equalityhumanrights.com/en/britain-fairer/britain-fairer-report

Accessed 28th January 2017

European Union (2016) MEM-TP project final report Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma http://ec.europa.eu/chafea/documents/health/mem-tp-final-report_en.pdf Accessed 8 September 2017

Evans, K. (2001) Expectations of newly qualified nurses, *Nursing Standard* 15 (41), 33-38

Feng, R. and Tsai, Y. (2012). Socialisation of new graduate nurses to practising nurses. *Journal of Clinical Nursing* 21(13–14), 2064–2071

Figueroa, S., Bulos, M., Forges, E., and Judkins Cohn, T. (2013). Stabilizing and retaining a quality nursing work force through the use of the married state preceptorship model. *The Journal of Continuing Education in Nursing*, 44(8), 365–373

Finch, H., Lewis, J. and Turley, C. (2014) Focus Groups. In Ritchie, J., Lewis J., McNaughton-Nicholls, C. and Ormston, R. (eds) (2014). *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. 2nd Edition. London: Sage. 211-242

Finlay, L. (2014) Engaging Phenomenological Analysis. *Qualitative Research in Psychology* 11, 121–141

Fitzgerald, E., Cronin, S. and Campinha-Bacote, J. (2009). Psychometric Testing of the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Student Version (IAPCC-SV). *Journal of Theory Construction and Testing,* 13(2), 64-68

Fine, G.A (1993) The sad demise, mysterious disappearance and glorious triumph of symbolic interactionism. *Annual Review of Sociology*, 19, 61-87

Flood, A. (2010) Understanding Phenomenology. *Nurse Researcher* 17(2), 7-15

Forbat, L., Hubbard, G. and Kearney, N. (2009) Patient and public involvement: models and muddles. *Journal of Clinical Nursing* 18 (18), 2547–2554

Foronda, C.L., Baptiste, D.L., Reinholdt, M.M and Ousman, K. (2015) A concept analysis of cultural sensitivity. *Journal of Transcultural Nursing* 27 (3) 210-217

The European Union Agency for Fundamental Rights (FRA) (2013) *Inequalities and multiple discrimination in access to and quality of healthcare.* http://fra.europa.eu/en/publication/2013/inequalities-discrimination-healthcare Accessed 16th January 2017

Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf Accessed 16th January 2017

Fusch, P. I. and Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *The Qualitative Report 20*(9), 1408-1416.

Gadamer, G.H (1989) *Truth and Method.* 2nd edition (translation by Weinsheimer J Marshall DG) London: Sheed and Ward.

Gagnon M, Jacob JD, McCabe J (2015) Locating the qualitative interview; reflecting on space and place in nursing research. *Journal of Research in Nursing* 20, 3, 203-215.

Gall, M. D., Borg, W. R. and Gall, J. P. (1996) *Educational research: An introduction.* (Sixth edition). White Plains, NY: Longman.

Gallagher, R.W. and Polanin, J.R. (2015) A meta-analysis of educational interventions designed to enhance cultural competence in professional nurses and nursing students *Nurse Education Today* 35(2), 333–340

Gan, S. (2012) *Lost in Translation: How Much Is Translation Costing the Nhs, and How Can We Both Cut Costs and Improve Service Provision*. 2020Health Report

http://www.2020health.org/2020health/Publications/publications-2012/Translation-Services.html Accessed 28th January 2017

Gentleman, A. (2010) Theresa May scraps legal requirement to reduce inequality. The Guardian, 17 November. Available at: http://www.guardian.co.uk/society/2010/nov/17/theresa-may-scraps-legal-requirement-inequality Accessed 22nd November 2014

Gerrish, K. (2000) Still fumbling along? A comparative study of the newly qualified nurse's perception of the transition from student to qualified nurse. *Journal of Advanced Nursing* 32(2), 473–480.

Giger, J.N. and Davidhizar, R. (2002) Transcultural Assessment Model. *Journal of Transcultural Nursing* 13(3), 185-188

Giger, J.N. and Davidhizar, R. (2004) *Transcultural Nursing: Assessment and Intervention*. 4th Edition. St. Louis, MO: Mosby

Gorgi, A. (2011) IPA and Science: a response to Jonathan Smith. *Journal of Phenomenological Psychology* 42(2), 195-216

Government Equalities Office (2012) *Evaluation of the Implementation of the Equality Act 2010: Report 1 - Organisational Approaches to Equality* CRSP 619. London: Crown Copyright

Grey, D. E. (2009) *Doing Research in the Real World (2nd edition)* Sage Publications: London.

Guba, E.G. and Lincoln, Y.S. (1994) Competing Paradigms in Qualitative Research. In Denzin, F.K and Lincoln, Y.S (Eds.) *Handbook of qualitative research* Thousand Oaks, CA: Sage Publications. 105-114

Gudykunst, W. B. and Kim, Y. Y. (2003) *Communicating with Strangers: an approach to intercultural communication 4th Edition*. New York: McGraw-Hill Companies Inc

Hacking, H. (1999) The Social Construction of What? Cambridge MA: Harvard University Press

Hagman, L.W. (2007) How New Mexico licensed registered nurses gained cultural self-efficacy in their stories. *Journal of Cultural Diversity* 14(4), 183-191

Ham, C., Baird, B., Gregory, S., Jabbal, J. and Alderwick, H. (2015) The NHS under the coalition government Part one: NHS reform. The Kings Fund.

https://www.kingsfund.org.uk/publications/nhs-under-coalition-government

Accessed 20 September 2017

Hammer, M.R, Bennett, M.J. and Wiseman, R. (2003) Measuring intercultural sensitivity: The Intercultural development inventory. *International Journal of Intercultural Relations,* 27, 421-443

Hammer, M. R. (2011) Additional Cross cultural validity testing of the Intercultural Development Inventory. *International Journal of Intercultural Relations,* 36, 474-487

Hammer, M. (2012). The Intercultural Development Inventory: A new frontier in assessment and development of intercultural competence. In M. Vande Berg, R.M. Paige, and K.H. Lou (Eds.), *Student Learning Abroad*. Sterling, VA: Stylus Publishing. 115-136

Hammersley, M. and Traianou, A. (2012) *Ethics in Qualitative Research*. London: Sage

Harris, R., Kelly, D., Hunt, J.A., Plant, H., Kelley, K., Richardson, A. and Sitzia J. (2008) Accessing elite nurses for research: reflections on the theoretical and practical issues of telephone interviewing. *Journal of Research in Nursing,* 13 (3), 236-248

Harmsen H; , Bernsen Rl Meeuwesen L; Thomas S; Dorrenboom G; Pinto D and Marc Bruijnzeels M (2005) The effect of educational intervention on intercultural communication: **r**esults of a randomised controlled trial *British Journal of General Practice,* May, *343-350*

Hart, C. (1998) Doing a Literature Review: Releasing the Social Science Imagination. London: Sage

Hart, P.L. and Mareno, N. (2014) Cultural challenges and barriers through the voices of nurses. *Journal of Clinical Nursing*, 23 (15–16), 2223–2233.

The Health Research Authority (HRA) (2014) Ethics Guidance: Payments and Incentives in Research http://www.hra.nhs.uk/documents/2014/05/hra-guidance-payments-incentives-research-v1-0-final-2014-05-21.pdf

Accessed 14th November 2015

Hemberg, J.A. and Vilander, S. (2017); Cultural and communicative competence in the caring relationship with patients from another culture. *Scandinavian Journal of Caring Sciences*, Feb 24.

DOI: 10.1111/scs.12403

Henderson, S., Kendell, E. and See, L. (2011) The effectiveness of culturally appropriate interventions to manage or prevent chronic disease in culturally and linguistically diverse communities: a systematic literature review. *Health and Social Care in the Community*, 19(3), 225–249

Higgins, G., Spencer, R.L. and Kane, R. (2010) A systematic review of the experiences and perceptions of the newly qualified nurse in the United Kingdom. *NET* 30(6), 499–508.

Hill, M.L (2006) 'Representing (g): Negotiating Multiple Roles and Identities in the Field and Behind the Desk', *Qualitative Inquiry* 12(5), 926–49

Holden, M.T. and Lynch, P. (2004) Choosing the Appropriate Methodology: Understanding Research Philosophy (RIKON Group). *The Marketing Review*, 4 397-409

Holland, K. and Hogg C. (2010) *Cultural Awareness in Nursing and Health Care: An introductory text.* 2nd Edition. London: Edward Arnold Publishers. 58-77

Holland, K., Roxburgh, M., Johnson, M., Topping, K., Watson, R., Lauder, W. and Porter, M. (2010*)* Fitness for practice in nursing and midwifery education in Scotland, United Kingdom*. Journal Of Clinical Nursing,* 19 (3-4), 461-469

Holloway, M. and Todres, L. (2006) The status of method: flexibility, consistency and coherence. *Qualitative Research,* 3(3), 345-357

Horvat, L., Horey, D., Panayiota, R, and Kis-Rigo, J. (2014) Cultural competence education for health professionals. *Cochrane Database of Systematic Reviews*, Issue 5. DOI:10.1002/14651858.CD009405.pub2

Houghton, C.E., Casey, D., Shaw, D. and Murphy, K. (2010) Ethical challenges in qualitative research: examples from practice. *Nurse Researcher* 18(1), 15 -25

House of Lords and House of Commons Joint Committee on Human Rights (2008) *A Life Like Any Other? Human Rights of Adults with Learning Disabilities*. Seventh Report of Session 2007-8 Volume 1. London: HMSO Crown Copyright

Hughes, R. and Huby, M. (2004) The construction and interpretation of vignettes in social research. *Social Work and Social Sciences Review* 11(1), 36-51

Hunsberger, M., Baumann, A., and Crea-Arsenio, M. (2013). The road to providing quality care: Orientation and mentorship for new graduate nurses. *Canadian Journal of Nursing Research* 45(4), 72–87

Hunter, L.P. (2008) A hermeneutic phenomenological analysis of midwives' ways of knowing during childbirth. Midwifery 24(4), 405-15

Hunter, D.J. (2001) Change of government: one more big bang health care reform in England's National Health Service. *International Journal of Health Services*, 41(1), 159–174

Husband, C, and Hoffman, E. (2009) *Transcultural communication and Health care practice. RCN On-line*. London: Royal College of Nursing. http://www.rcn.org.uk/resources/transcultural/communication/index.php Accessed 16th January 2010

Ingram, R.R. (2012) Using Campinha-Bacote's process of cultural competence model to examine the relationship between health literacy and cultural competence. *Journal of Advanced Nursing* 68(3), 695-704

Inman, A.G. (2006) Supervisor Multicultural competence and its relation to supervisory process and outcome. *Journal of Marital and Family Therapy* 32(1) 73-85

International Council of Nurses (ICN) (2012) *The ICN Code of Ethics for Nurses*. http://www.icn.ch/who-we-are/code-of-ethics-for-nurses/ Accessed 12th January 2016

INVOLVE (2015) *Public involvement in research: values and principles framework* INVOLVE: Eastleigh.

Isaacs, A.N., Raymond, A., Jacob, E., Jones, J. McGrail, M. and Drysdale, M. (2016) Cultural desire need not improve with cultural knowledge: A cross-sectional study of student nurses. *Nurse Education in Practice*, 19, 91–96

Jacelon, C.S. and Imperio, K. (2005) Participant Diaries as a source of data in research with older adults. *Qualitative Health Research* 15(7), 991-997

Jack, S. (2008) Guidelines to support nurse-researchers reflect on role conflict in qualitative interviewing, *The Open Nursing Journal,* 2: 58-62.

Jackson, D., Daly, J. and Davidson, P. (2008) Interviews. Chapter 27 in Watson R, McKenna H, Cowman S and Keady J (2008) *Nursing Research Designs and Methods.* Edinburgh: Churchill Livingstone Elsevier

Jessiman, W.C. (2013) 'To be honest, I haven't even thought about it' – recruitment in small-scale, qualitative research in primary care. *Nurse Researcher* 21(2), 18-23

Jirwe, M. (2011) Analysing qualitative data. *Nurse Researcher* 18 (3) 4-5

Jirwe, M., Gerrish, K., Keeney, S. and Emani, A. (2009) Identifying the core components of cultural competence: findings from a Delphi study. *Journal of Clinical Nursing,* 18, 2622-2634

Johnson, M.R.D. (2004) Cross-Cultural Communication in Health. *Clinical Cornerstone* 6(1), 50-52

Johnson, M.R.D. (2009) End of life care in ethnic minorities. (Editorial) BMJ 338:a2989

Johnstone MJ, Kanitsaki O. (2006) Culture, language, and patient safety: making the link. *International Journal for Quality in Health Care* 2006 18(5), 383–8

Johnston, C.M., Wallis, M., Oprescu, F.I. and Gray, M. (2016) Methodological considerations related to researchers using their own experiences of a phenomenon within phenomenology. *Journal of Advanced Nursing* 73(3), 574-584

Jootun, D., McGhee, G. and Marland, G.R. (2009) Reflexivity: promoting rigour in qualitative research. *Nursing Standard* 23(23), 42-46

Kaba, A. and Beran, T. (2014) Twelve tips to guide effective participant recruitment for interprofessional education research. *Medical Teacher* 36(7), 578-584

Kai, J., Beavan, J., Faull, C., Dodson, L., Gill, P. and Beighton, A. (2007) Professional uncertainty and disempowerment to ethnic diversity in healthcare: a qualitative study. *PloS Medicine* 4(11) e323

Kaufman, G. and McCaughan, D. (2013) The effect of organisational culture on patient safety. *Nursing Standard*. 27(43), 50-56

Kezar, A. (2000) The importance of pilot studies: beginning the hermeneutic circle. *Research In Higher Education* 41(3), 385-400

Kelly, J. and Ahern, K. (2009). Preparing nurses for practice: A phenomenological study of the new graduate in Australia. *Journal of Clinical Nursing* 18(6), 910–918

Kim, Y. (2011) The pilot study in qualitative inquiry: identifying issues and learning lessons for culturally competent research. *Qualitative Social Work* 10(2), 190-206.

Krauskopf, P.B. (2008) An international healthcare experience: influencing cultural competency of nursing students? A pilot study. *Southern Online Journal of Nursing Research* 8 (2), 1

Krauss, S.E. (2005) Research Paradigms and Meaning Making: A Primer. *The Qualitative Report*, 10(4), 758-770

Kumaran, S. and Carney, M. (2014) Role transition from student nurse to staff nurse: Facilitating the transition period. *Nurse Education in Practice* 14(6), 605–611

Kim, Y (2011) Lessons for Culturally Competent Research The Pilot Study in Qualitative Inquiry: Identifying Issues and Learning. *Qualitative Social Work* 10 (2), 190-206

Kim-Godwin, Y.S., Clarke, P.N. and Barton, L. (2001) A model for the delivery of culturally competent community care *Journal of Advanced Nursing* 35(6), 918 – 925

Kirton, G. and Green, A.M. (2005) *The Dynamics of Managing Diversity: A critical approach.* 2nd Edition. Elsevier Butterworth Heinemann Publishers

Kleinman, A. and Benson, P, (2006) Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It. *PLoS Medicine* 3(10): e294.

Kline, R. (2014) *The "snowy white peaks" of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England*. Middlesex University Research Repository. https://www.england.nhs.uk/wp-content/uploads/2014/08/edc7-0514.pdf Accessed 22nd October 2016

Kline, R., Naqvi, H., Razaq, S.A. and Wilhelm, R. (2017) NHS Workforce Race Equality Standard 2016 Data Analysis Report for NHS Trusts. https://www.england.nhs.uk/wp-content/uploads/2017/03/workforce-race-equality-standard-data-report-2016.pdf Accessed 24th April 2017

Kodjo, C. (2009) Cultural competence in clinician communication. *Pediatrics in review* 30(2) 57–63

Koskinen, L., Jokinen, P., Blackburn, D., Gilmer, M. and McGill, J. (2004) Learning intercultural competence in a transatlantic nurse education project. *Diversity in Health and Social Care* 2004 1(2), 99-106

Krainovich-Miller, B., Yost, J.M., Norman, R.G., Auerhahn, C., Dobal, M., Rosedale, M., Lowry, M. and Moffa, C. (2008) Measuring cultural awareness of nursing students: a first step toward cultural competency. *Journal of Transcultural Nursing* 19 (3) 250-8

Kramer M. (1974) *Reality Shock: Why Nurses Leave Nursing*. St Louis: C.V. Mosby Company

Kramer, M., Maguire, P., Schmalenberg, C., Halfre, D., Budin, W., Goodloe, L. and Lemke, J. (2012). Components and strategies of nurse residency programs effective in new graduate socialization. *Western Journal of Nursing Research*, 35(5), 566–589

Kramer-Kile, M.L. (2012). Situating Methodology within Qualitative Research. *Canadian Journal of Cardiovascular Nursing, 22*(4), 27–31

Krauss, S.E. (2005) Research Paradigms and Meaning Making: A Primer**.** *The Qualitative Report* 10 (4) 758-770

Kumaran, S. and Carney, M. (2014) Role transition from student nurse to staff nurse: facilitating the transition period. *Nurse Education and Practice* 14(6), 605-11

Lampley, T.M., Little, K.E., Beck-Little, R. and Xu, Y. (2008) Cultural competence of North Carolina nurses: a journey from novice to expert. *Home Health Care Management and Practice* 20(6), 454-461

Lave, J.and Wenger, E. (1991). *Situated learning: Legitimate peripheral participation*. Cambridge: Cambridge University Press

Leininger, M. (1988). *Care: The essence of nursing and health*. Detroit: Wayne State University Press. (Reprinted with original work published (1984) by Slack Pub. Inc., Thorofare, NJ.

Leininger, M. (2002) Culture Care Theory: a major contribution to advance transcultural nursing knowledge and practices. *Journal of Transcultural Nursing* 13(3), 189-192

Lewis, J. and McNaughton-Nicholls, C. (2014) Design Issues. In Ritchie, J., Lewis J., McNaughton-Nicholls, C. and Ormston, R. (eds) (2014). *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. 2nd Edition. London: Sage. 47-76

Lie DA, Lee-Rey E, Gomez A, Bereknyei S, Braddock CH: Does cultural competency training of health professionals improve patient outcomes? A systematic review and proposed algorithm for future research. *Journal General Internal Medicine* 2011, 26(3), 317–325

Likupe, G. and Archibong, A (2013) Black African Nurses' experiences of equality, racism and discrimination in the National Health Service. *Journal of Psychological Issues in Organizational Culture,* 3(S1), 227-246

Lima, S., Newall, F., Jordan, H.L, Hamilton, B and Kinney, S. (2016). Development of competence in the first year of graduate nursing practice: a longitudinal study. *Journal of Advanced Nursing*, 72(4) 878-888

Lincoln, Y. S. and Guba, E. G. (2000) *Paradigmatic Controversies, Contradictions, and Emerging Confluences*. In Denzin, N. K. and Lincoln, Y. S. (Eds.) *Handbook of Qualitative Research.* 2nd ed. Thousand Oaks, CA: Sage Publications

Loftin, C., Hartin, V., Branson, M. and Reyes, H. (2013) Measures of Cultural Competence in Nurses: An Integrative Review. *The Scientific World Journal*. Article ID 289101, http://dx.doi.org/10.1155/2013/289101

The London Deanery (2009) *What is cultural competence?* Available at http://www.lpmde.ac.uk/lpmde/equality-diversity/cultural-competence/files/cultural-competence-definition.pdf Accessed 23rd February 2014

Lustig, M.W. and Koester, J. (2010) *Intercultural competence: interpersonal communication across cultures.* 6th edition. Boston: Pearson Education Inc Publishers

Maben, J. Latter, S. and MacLeod, C. J. (2006) The theory-practice gap: impact of professional-bureaucratic work conflict on newly qualified nurses. *Journal of Advanced Nursing* 55(4), 465-477

Machi, L.A (2009) *The Literature Review: Six steps to Success* London: Corwin Press

Magnusson, C., Finnerty, G. and Pope, R. (2005) Methodological triangulation in midwifery education research. *Nurse Researcher* 12 (4), 30-39

Marmot, M. (2010) *Fair society, healthy lives: the Marmot Review : strategic review of health inequalities in England post-2010*. ISBN 9780956487001

Marshall, C., Rossman, G. B. (2011). *Primary Data Collection Methods Designing Qualitative Research*. Los Angeles, CA: Sage. 137-177

Mason, M. (2010) Sample size and Saturation in PhD studies Using Qualitative Interviews. Forum: Qualitative Social Research 11(3) ISSN 1438-5627. Available at: <http://www.qualitative-research.net/index.php/fqs/article/view/1428/3027 Accessed 22 May 2017

Mason, D.M. and Ide, B. (2013) Adapting qualitative research to technology savvy adolescents. *Nurse Researcher* 21, 5, 40-45.

Matua, G.A. and Van Der Wal, D.M. (2015) Differentiating between descriptive and interpretative phenomenological research approaches. *Nurse Researcher* 22(6) 22-27

Maxwell, E. (2017) Perspectives: The primacy of compassion in nursing, necessary but not sufficient? *Journal of Research in Nursing* 22(1-2) 169-172

McCance, T. and Mcilfatrick, S. (2008) Phenomenology. In Watson R, McKenna H, Cowman S and Keady J (eds). *Nursing Research Designs and Methods*. Edinburgh: Churchill Livingston, Elsevier. 231-241

McClimens, A., Brewster, J. and Lewis, R., 2014. Recognising and respecting patients' cultural diversity. *Nursing standard* 28(28), 45–52

McColl, G.J., Goss, B.D., Flynn, E.M. and Dodds, A.E (2014) “They liked it if you said you cried”: how medical students perceive the teaching of professionalism. *Medical Journal of Australia* 200(1), 20

McGee, P. and Johnson, M.R.D. (2014) Developing Cultural Competence in Palliative Care. *British Journal of Community Nursing* 19(2), 91-93

Mealer, M. Jones, J. (2014) Methodological and ethical issues related to qualitative telephone interviews on sensitive topics. *Nurse Researcher* 21, 4, 32-37.

Meleis, A.F., Sawyer, L.L., Im, E.O., Messias, D.K.F. and Schumacher, K. (2000) Experiencing Transitions: An Emerging Middle-Range Theory. *Advanced Nursing Science* 23(1) 12-28

Miller, T. and Boulton, M. (2007). Changing constructions of informed consent: Qualitative research and complex social worlds. *Social Science & Medicine 65*, 2199–2211

Moore, J. (2012) A personal insight into researcher positionality. *Nurse Researcher* 19(4), 11–14

Mor Barak, M.E. (2005) *Managing Diversity: Toward a Globally inclusive workplace.* SAGE Publications: Thousand Oaks, London, New Delhi.

Murray-Parahi, P., Digiacomo, M., Jackson, D. and Davidson, P.M. (2016) New graduate registered nurse transition into primary health care roles: an integrative literature review. *Journal of Clinical Nursing*, 25, 3084–3101.

Myers, V. and Wooten, L.P. (2009) Extraordinary Diversity Management Practices and Quality of care. *Organizational Dynamics* 38(4), 297-304

Naravanasamy, A. (2002) The ACCESS model: a transcultural nursing practice framework *British Journal of Nursing* 11 (9), 643-650

Naravanasamy, A. and White, E. (2005) A review of Transcultural Nursing. *Nurse Education* Today 25 (2), 102-111

National Health Service (NHS) England 2016a. NHS England response to the specific duties of the Equality Act. https://www.england.nhs.uk/wp-content/uploads/2016/02/nhse-specific-duties-equality-act.pdf Accessed 21st January 2017

National Health Service (NHS) England 2016b. Compassion in practice: evidencing the impact. https://www.england.nhs.uk/wp-content/uploads/2016/05/cip-yr-3.pdf Accessed 21st January 2017

National Nursing Research Unit (NNRU) (2008) Nursing competence: what are we assessing and how should it be measured? Policy Issue 18. http://www.kcl.ac.uk/nursing/research/nnru/policy/Policy-Plus-Issues-by-Theme/Boundaries-regulation-competence/PolicyIssue18.pdf Accessed 22nd November 2014

National Voices (2012) *NOT THE FRANCIS REPORT A National Voices Report on How to Ensure Safety and Quality.* London: National Voices

NIHR Evaluation, Trials and Studies Coordinating Centre (NETSCC) (2013) Glossary. www.nets.nihr.ac.uk/glossary Accessed 5 July 2016

Novick, G. (2008) Is There a Bias Against Telephone Interviews in Qualitative Research? *Research in Nursing and Health,* 31, 391-398

Numminen, O., Leino-Kilpi, H., Isoaho, H. and Meretoja, R. (2015a). Newly Graduated Nurses' Competence and Individual and Organizational Factors: A Multivariate Analysis. *Journal of Nursing Scholarship* 47(5) 446-457

Numminen, O., Leino-Kilpi, H., Isoaho, H. and Meretoja, R. (2015b) Ethical climate and nurse competence - newly graduated nurses' perceptions. *Nursing Ethics* 22(8), 845–859.

Nursing and Midwifery Council (2006*) Preceptorship Guidelines* Circular 21/2006 London: NMC

Nursing and Midwifery Council (2010) *Standards for Pre-registration Nursing Education.* London: NMC

Nursing and Midwifery Council (2014) *Standards for competence for registered nurses*. https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-competence-for-registered-nurses.pdf Accessed 14th December 2015

Nursing and Midwifery Council (2015). *The Code: Standards of conduct, performance and ethics for nurses and midwives* NMC: London

Nursing and Midwifery Council (2016) Annual Equality and Diversity Report 2015-6 https://www.nmc.org.uk/globalassets/sitedocuments/annual_reports_and_accounts/equality-and-diversity-report-2015-16.pdf Accessed 21 August 2016

Nursing and Midwifery Board of Australia (2013) *Code of Ethics for Nurses and Code of Professional Behaviour*. http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx Accessed 21 August 2016

O'Brien, M.R. and Clark, D. (2012) Unsolicited written narratives as a methodological genre in terminal illness: challenges and limitations. *Qualitative Health Research*. 22(2) 274-284

Office of Minority Health (OHM) (2013) National standards for culturally and linguistically appropriate services in health and health care: a blueprint for advancing and sustaining CLAS policy and practice; 2013. U.S. Department of Health and Human Services. Available at https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53 Accessed 7 September 2017

Ohman, A. (2005) Qualitative Methodology for Rehabilitation Research (Review Article) *Journal of Rehabilitation Medicine* 37, 273–280

Oliver, C. (2012). The relationship between symbolic interactionism and interpretative description. *Qualitative health research* 22(3), 409–15

Olt, H., Jirwe, M., Gustavsson, P. and Emani, A. (2010) Psychometric Evaluation of the Swedish Adaptation of the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals Revised (IAPCC-R). *Journal of Transcultural Nursing* 21 (1) 55-64

Omeni, E., Barnes, M., MacDonald, D., Crawford, M. and Rose, D. (2014) Service user involvement: impact and participation: a survey of service user and staff perspectives. *BMC Health Services Research*, 14, 491

http://www.biomedcentral.com/1472-6963/14/491

O'Mara, J. and Richter, A. (2006) *Global Diversity and Inclusion Benchmarks.* http://www.kiwata.com/pdf/GDI_benchmarks.pdf Accessed 24th January 2017

Ormston, R., Spencer, L., Barnard, M. and Snape, D. (2014) In Ritchie, J., Lewis J., McNaughton-Nicholls, C. and Ormston, R. (eds) (2014). *Qualitative*

Research Practice: A Guide for Social Science Students and Researchers. 2nd Edition. London: Sage. 1 – 25

Orvik, A., Larun, l. Berland, A. and Ringsberg, K.C. (2013) Situational Factors in Focus Group Studies: A Systematic Review, *International Journal of Qualitative Methods,* 12, 338-358

Paige, M.R., Jacobs-Cassuto, M., Yershova, Y.A. and DeJaeghere, J. (2003) Assessing Intercultural sensitivity: an empirical analysis of the Hammer and Bennett Intercultural Development Inventory *International Journal of Intercultural Relations* 27, 467-486

Parahoo, K. (2006) *Nursing Research: Principles, Process and Issues*. London: Macmillan Press Ltd

The Patients Association (2012) *Stories from the Present – Lessons for the future.* Harrow, Middlesex: The Patients Association

Papadopolous, L. (2006) The Papadopolous, Tilki and Taylor Model of developing cultural competence. In Papadopolous, L (2006) (ed) *Transcultural Health and Social Car: Development of Culturally Competent Practitioners.* London: Churchill Livingstone Elsevier. 7-25

Papadopolous, I., Shea, S., Taylor, G. Pezzella, A. and Foley, L. (2016) Developing tools to promote culturally competent compassion, courage, and intercultural communication in healthcare. *Journal of Compassionate Healthcare* 3(2) DOI 10.1186/s40639-016-0019-6

Patton, M.Q. (2002) *Qualitative Research and Evaluation Methods*. 3rd Edition. Thousand Oaks, CA: Sage

Perry, L.B and Southwell M. (2011) Developing intercultural understanding and skills: models and approaches. *Intercultural Education* 22 (6), 453-466

Phillips, C., Esterman, A. and Kenny, A. (2013) The theory of organisational socialisation and its potential for improving transition experiences for new graduate nurses. *Nurse Education Today* 35, 118-124

Phillips, C., Kenny, A., Esterman, A. and Smith, C. (2014). A secondary data analysis examining the needs of graduate nurses in their transition to a new role. *Nurse Education in Practice* 14, 106–111

Price, S.L. (2009) Becoming a nurse: A meta-study of early professional socialization and career choice in nursing. *Journal of Advanced Nursing* 65(1), 11-19

Priest, H., Roberts, P., and Woods, L. (2002) An overview of three different approaches to the interpretation of qualitative data. Part 1: theoretical issues. *Nurse Researcher* 10 (1), 30-42

Pringle, J., Drummond, J. and Hendry E. (2011) Interpretative phenomenological analysis: a discussion and critique. *Nurse Researcher* 18(3) 20-24

Purnell, L. (2000) A description of the Purnell Model for Cultural Competence. *Journal of Transcultural Nursing* 11(1) 40-46

Rapport, F. (2004) *New methodologies in health and social care research* (eds). London: Routledge

Reader, T.W., Gillespie, A. and Roberts, J. (2014). Patient complaints in healthcare systems: a systematic review and coding taxonomy. *BMJ quality and safety* 23, 678–689.

Redmond, R. and Curtis, E. (2009) Focus groups: principles and process *Nurse Researcher* 16(3), 57-69

Rejon, C.J., and Watts, C. (2014) *Supporting professional nurse socialisation: Findings from evidence reviews*. London: Royal College of Nursing https://www2.rcn.org.uk/__data/assets/pdf_file/0010/559225/Socialisation_review_REDRAFT_CW_03_01_14.pdf Accessed 12th January 2016

Rew, L., Becker, H., Cookston, J., Khosropour, S. and Martinez, S. (2003) Measuring Cultural Awareness in Nursing Students. *Journal of Nursing Education* 42 (6) 249-257

Ritchie, J., Lewis J., Elam, G., Tennant, R. and Rahim, N. (2014) Designing and Selecting Samples. In Ritchie, J., Lewis J., McNaughton-Nicholls, C. and Ormston, R. (eds) (2014). *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. 2nd Edition. London: Sage. 111-145

Roberts, D. and Johnson, M. (2009) Newly qualified nurses: competence or confidence? *Nurse Education Today (Editorial)* 29, 467-468

Robinson, S. and Griffiths, P. (2009) *Scoping review: Preceptorship for newly qualified nurses; impact, facilitators and constraints*. London: National Nursing Research Unit (NNRU) https://pdfs.semanticscholar.org/a93f/9453858698005a25f298ce5d917ab079b90d.pdf Accessed 24th January 2017

Rossman, R. B., and Ralllis, S. F. (1998). *Learning in the field: An introduction to qualitative research.* Thousand Oaks, CA: Sage.

Royal College of Nursing (RCN) (2009) *Research Ethics: Guidance for Nurses.* London: Royal College of Nursing

Royal College of Nursing (RCN) (2010) Principles of Nursing Practice https://www.rcn.org.uk/professional-development/principles-of-nursing-practice Accessed 6th December 2016

Rush, K.L., Adamack, M., Gordon, J. and Meredith, L. (2013) Best practices of formal new graduate nurse transition programs: An integrative review. *International Journal of Nursing Studies* 50(3), 345–356

Saha, S., Saint, S. and Christakis, D.A. (2003) Impact Factor: a valid measure of journal quality. *Journal of Medical Library Association* 91 (1) 42-6

Saha, S., Beach, M.C. and Cooper, L.A. (2008) Patient Centredness, Cultural Competence and Healthcare Quality *Journal National Medical Association* 100(11) 1275-1285

Sale, J.E.M; Lohfeld, L.H. and Brazil, J. (2002) Revisiting the Quantitative-Qualitative Debate: Implications for Mixed-Methods Research. *Quality and Quantity* 36(1) 43–53

Sampson, H. (2004) Navigating the Waves: The Usefulness of a Pilot in Qualitative Research. *Qualitative Research* 4(3) 383–402

Searl, K.R., Dwyer, T., Moxham, L., Happell, B. and Sander, T. (2011) Rediscovering the essence of nursing: Exploring the impact of a clinical experience in Thailand for undergraduate nursing students from Australia. *Nurse Education Today* 31(8) 892-897

Secomb, J.M. and Smith, C. (2011) A mixed method pilot study: the researchers' experience. *Contemporary Nurse* 39(1), 31-35

Shapiro, J., Hillingshead, J. and Morrison, E.H. (2002) Primary Care Resident, faculty, and patient views of barriers to cultural competence, and the skills needed to overcome them. *Medical Education* 36, 749-757

Shared Intelligence (2012) *Evaluation of the Equality Delivery System (EDS) for the NHS*. Final Report. https://www.england.nhs.uk/wp-content/uploads/2013/08/8-eds-eval-fnl-rpt291012.pdf Accessed 20th November 2013

Shen, Z. (2015) Cultural Competence Models and Cultural Competence Assessment Instruments in Nursing: A literature review. *Journal of Transcultural Nursing* 26(3), 308-321

Shih, F.J. (1998) Triangulation in nursing research: issues of conceptual clarity and purpose. *Journal of Advanced Nursing.* 28, 3, 631-641.

Silverman, D. (2011) *Interpreting Qualitative Data: Methods for analysing talk, text and interaction*. 4th edition. London: Sage

Smith JA (2008) *Qualitative Psychology: A Practical Guide to Research Methods*. Second edition. Sage Publications, London.

Smith, B. (2016) *Equal Rights Review. Special Focus Intersectionality*.

http://www.equalrightstrust.org/ertdocumentbank/Equal%20Rights%20Review%20Volume%2016%20Intersectionality.pdf Accessed 21st January 2017

Smith, J., Bekker, H. and Cheater, F. (2011) Theoretical versus pragmatic design in qualitative research. *Nurse Researcher* 18 (2) 39-51

Snelson, C.L. (2016) Qualitative and Mixed Methods Social Media Research: A Review of the Literature. International Journal of Qualitative Methods, 14, 5-33

Snowden, M. (2015) The use of diaries in research. *Nursing Standard* 29 (44) 26-41

Somek, A. (2011) Engineering Equality: An essay on European anti-discrimination Law. *Oxford Scholarship Online,* Oxford ISBN-13: 9780199693375

Songwathana, P. and Siriphan, S. (2015) Thai Nurses' Cultural Competency in Caring for Clients Living in a Multicultural Setting. *Pacific Rim International Journal of Nursing Research* 19(1), 19-31

Spencer, L., Ritchie J., O'Conner, W., Morrell, G. and Ormston, R. (2014) Analysis in practice. In Ritchie, J., Lewis J., McNaughton-Nicholls, C. and Ormston, R. (eds) (2014). *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. 2nd Edition. London: Sage. 295-345

Sturges, J.E. and Hanrahan, K.J. (2004) Comparing Telephone and Face-to-Face Qualitative Interviewing: a Research Note. *Qualitative Research* 4(1), 107-118

Shih, F.J. (1998) Triangulation in nursing research: issues of conceptual clarity and purpose. *Journal of Advanced Nursing* 28(3), 631-641

Tavalli, A. G., Kabir, Z. N. and Jirwe, M. (2014). Ethnic Swedish parents' experiences of minority ethnic nurses' cultural competence in Swedish paediatric care. *Scandinavian Journal of Caring Science,* 28, 255-263

Teal, C.R. and Street, R.L. (2009) Critical elements of culturally competent communication in the medical encounter: a review and model. *Social Science and Medicine* 68 (3) 533-43

ten Hoeve, Y., Jansen, G. and Roodbol (2014) The nursing profession: public image, self-concept and professional identity. A discussion paper. *Journal of Advanced Nursing*, 70(2) 295-309

Thabane, L., Ma, J., Chu, R., Cheng, J., Ismaila, A., Rios, L.R., Robson, R., Thabane, M., Giangregorio, J. and Goldsmith, C.H (2010) A tutorial on pilot studies: the what, why and how. *BMC Medical Research Methodology* 10(1) DOI: 10.1186/1471-2288-10-1

Thomas JA (2015) Using unstructured diaries for primary data collection. *Nurse Researcher* 22(5), 25-29

Thom, T.D. and Tirado, M.D. (2006) Development and Validation of a Patient Reported Measure of Physician Cultural Competency *Medical Care Research and Review* 63(5), 636-655

Torsvik, M. and Hedlund, M. (2008) Cultural encounters in reflective dialogue about nursing Care: a qualitative study. *Journal of Advanced Nursing*. 63 (4) 389-396

Traynor, M (2015) Focus group research. *Nursing Standard* 29, 37, 44-48

Trier-Bieniek, A. (2012) Framing the telephone interview as a participant-centred tool for qualitative research: a methodological discussion. *Qualitative Research* 12(6), 630-644

Truong M; Yin Paradies Y and Naomi Priest N (2014) Interventions to improve cultural competency in healthcare: a systematic review of reviews. *BMC Health Services Research*, 14(99) DOI: 10.1186/1472-6963-14-99

van Teijlingen, E.R, and Hundley V (2001) *The importance of pilot studies.* Social Research Update Issue 35, Department of Sociology, University of Surrey http://sru.soc.surrey.ac.uk/SRU35.pdf

Tuttas, C. (2015). Perceived racial and ethnic prejudice and discrimination experiences of minority migrant nurses: A literature review. *Journal of Transcultural Nursing 26*(5) 514-520

Waite, R. and Calamaro, C.J. (2009) Cultural Competence: A Systemic Challenge to Nursing Education, Knowledge Exchange, and the Knowledge Development Process *Perspectives in Psychiatric Care* 46(1), 74–80

Walby, S., Armstrong, J. and Humphreys, L. (2008) *Review of Equality Statistics. Research Report 1.* Equality and Human Rights Commission. EHRC: London

Ward, K., Gott, M. and Hoare, K. (2015). Participants' views of telephone interviews within a grounded theory study. *Journal of Advanced Nursing* 71(12), 2775-2785

Watson, R. (2008) Longitudinal Studies. In Watson R, McKenna H, Cowman S and Keady J (eds). *Nursing Research Designs and Methods*. Edinburgh: Churchill Livingston, Elsevier. 261-278

Webster, S., Lewis, J. and Brown, A. (2014) Ethical Considerations in Qualitative Research. In Ritchie, J., Lewis J., McNaughton-Nicholls, C. and Ormston, R. (eds) (2014). *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. 2nd Edition. London: Sage. 77-110

West, E., Nayar, S. and Taskila, T. and Al-Haboubi, M. (2017) *The Progress and Outcomes of Black and Minority Ethnic (BME) Nurses and Midwives through the Nursing and Midwifery Council's Fitness to Practise Process*. NMC Report https://www.nmc.org.uk/globalassets/sitedocuments/other-publications/bme-nurses--midwives-ftp-research-report.pdf Accessed 22nd April 2017

Wheeler, R.M., Foster, J.W. and Hepburn, K.W., 2014. The experience of discrimination by US and Internationally educated nurses in hospital practice in the USA: A qualitative study. *Journal of Advanced Nursing* 70(2), 350–359

Whittemore, R. and Knafl, K. (2005) The integrative review: updated methodology. *Journal of Advanced Nursing* 52(5) 546-553

Williams, S.D., Hansen, K., Smithey, M., Burnley, J., Koplitz, M., Koyama, K., Young, J. and Bakos A (2014) Using social determinants of health to link health workforce diversity, care quality and access, and health disparities to achieve health equity in nursing. *Public Health Reports* 129(2), 32–36

Wilson, B.B., and Myers, K. M. (2000). Situated Cognition in Theoretical and Practical Context. In Jonassen, D. and Land, S (Eds.) *Theoretical Foundations of Learning Environments.* Mahway, NJ: Lawrence Erlbaum Associates. 57–88

Williamson, M. and Harrison, L. (2010) Providing culturally appropriate care: A literature review *International Journal of Nursing Studies* 47, 761–769

Widger, T., Prosser, S., Rogers, S. and Hutton, C. (2011) *The performance of the health sector in meeting the Public Sector Equality Duties: moving towards effective equality outcomes.* Trowbridge, Wiltshire: Focus Consultancy Ltd

White, C., Woodfield, K., Ritchie, J. and Ormston, R. (2014) Writing up Qualitative Research. In Ritchie, J., Lewis J., McNaughton-Nicholls, C. and Ormston, R. (eds) (2014). *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. 2nd Edition. London: Sage. 367-400

Whitehead, B., Owen, P., Holmes, D., Beddington, E., Simmons, M., Henshaw, L., Barton, M. and Walker, C. (2013) Supporting newly qualified nurses in the UK: a systematic literature review. *Nurse education today* 33(4), 370–7

Whitehead, B., Owen, P., Henshaw, L., Beddingham, E. and Simmons, M. (2016) Supporting newly qualified nurse transition: A case study in a UK hospital*. Nurse Education Today* 36, 58–63

White-Means, S, Dong, Z, Hufstader, M and Brown, LT (2009) Cultural competency, race, and skin tone bias among pharmacy, nursing, and medical students: implications for addressing health disparities. *Medical Care Research and Review* 66(4), 436-55

WHO Regional Office for Europe (2013) *Health 2020: A European policy framework supporting action across government and society for health and well-being*. http://www.euro.who.int/en/publications/abstracts/health-2020-a-european-policy-framework-supporting-action-across-government-and-society-for-health-and-well-being Accessed 7 September 2017

WHO Regional Office for Europe (2014) *Review of social determinants and the health divide in the WHO European Region*. http://www.euro.who.int/en/health-topics/health-policy/health-2020-theeuropean-policy-for-health-and-well-being/publications/2013/reviewof-social-determinants-and-the-health-divide-in-the-who-europeanregion.-final-report Accessed 7 September 2017

WHO (2015) A Roadmap to Implementing Health 2020 – the Experience of San Marino

http://www.euro.who.int/__data/assets/pdf_file/0020/281531/Roadmap-Implementing-Health2020Experience-SanMarino.pdf?ua=1 Accessed 8 September 2017

Woll H (2013) Process diary as methodological approach in longitudinal phenomenological research. *The Indo-Pacific Journal of Phenomenology* 13(2), 1-11

Woods L., Priest H., and Roberts P (2002) An overview of three different approaches to the interpretation of qualitative data. Part 2: practical illustrations. *Nurse Researcher* 10(1), 30-42

Wray, J., Archibong, U. and Walton, S. (2016) Why undertake pilot work in a qualitative PhD study? Lessons learnt to promote success. *Nurse Researcher* 24(3), 31-35

Yeo, A., Legard, R., Keegan, J. and Ward, K. (2014) In-depth interviews. In Ritchie, J., Lewis J., McNaughton-Nicholls, C. and Ormston, R. (eds) (2014). *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. 2nd Edition. London: Sage. 177-210

Zhao, J., Gao, S., Wang, J., Liu, X. and Hao, Y. (2016) Differentiation between two healthcare concepts: Person-centered and patient-centered care. *International Journal of Nursing Sciences* 4(3), 398-402

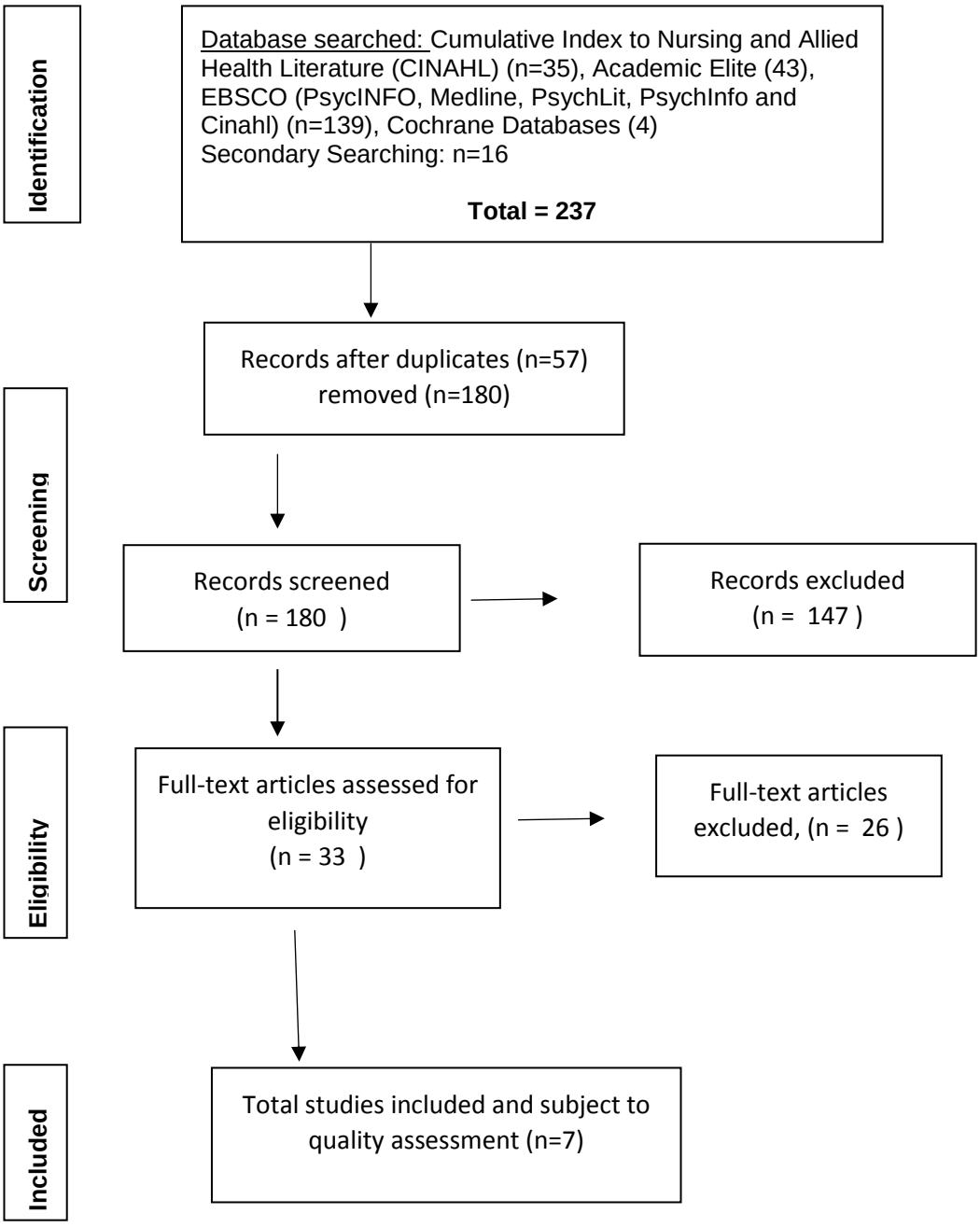
Appendix 1: Core Concepts in (selected) models of Cultural Competence and key descriptions of behaviour and, or skills

Author	Model / Theory	Key Aspects of Model and Descriptor of skills, behaviours, and, or practice
Leininger 1988, 2002	Sunrise or Universality Model Theory of Culture Care: Diversity and Universality	Model provides multiple holistic factors which influence or impact upon cultural care. Based around the core concept of care and, or caring, and can be used by nurses to undertake a wide ranging cultural assessment. The assessment takes into account biological, psycho-social, economic, educational, environmental and political / economic factors (e.g. gender, ability and disability, age, sexual orientation, occupation, socio-economic status, interpersonal relationships, communication and language, appearance, dress, foods and meal preparation preferences). The assessment is informed and guided by all these factors and the model provides a framework for nurses to apply these to care delivery to meet the needs of patients in a way that is meaningful for them.
Campinha-Bacote (2002)	The process of cultural competence in the delivery of healthcare services: a model of care	The model is comprised of five core domains; Awareness, Knowledge, Skill, Cultural Encounters and Cultural Desire. These core domains are linked together in the process of becoming culturally competence. Cultural skill is regarding as the nurses' ability to collect relevant cultural data and to conduct a culturally appropriate assessment of patient needs and health issues to inform care planning and delivery. Skill is also needed in conducting a physical assessment that takes into account differences (e.g. skin colour)
Giger and Davidhizar (2002, 2004)	Model of Transcultural Assessment and Intervention	Each person is seen as a unique (cultural) individual and the assessment framework was based on six cultural phenomena which were key domains which were considered relevant to all individuals. These are applied by nurse to the assessment and planning of care

		• Communication (verbal and non-verbal means) • Space (different cultural perspectives on what is appropriate in terms of personal, tactile and visual spaces between nurse and patient) • Social organisation (family, social structures, communities, kinship) • Time (different cultural perspectives on patterns of time and how this impacts on how people carrying out everyday activities • Environmental Control (persons perception of control over in relation to health and environment) • Biological variation (epidemiology of individual patient)
Papadopoulos (2006)	Papadopoulos, Tikki and Taylor model	4 levels or stages to the model; 1. Cultural awareness (exploring personal values, beliefs, assumptions and the nature of identity) 2. Cultural knowledge learning via interaction and contact as well as study (particularly power relationships and inequalities) 3. Cultural sensitivity requires reframing of the professional position to view patients as true partners and learning negotiation and facilitation. 4. Cultural competence is then the final stage in which the previous stages are integrated and applied to skills including recognising and challenging all forms of discrimination Skills specifically are • Assessment skills • Clinical skills and diagnosis • Caring skills

		• Addressing inequalities and discrimination, avoiding prejudices
Purnell and Paulunka (2008)	Purnells' model Model of Cultural Competence	This model proposes learning and development through 4 stages which starts with unconscious incompetence, moving up through two further stages (conscious incompetence and conscious competence) through to unconscious competence. Presented as concentric circulates which make up the person, the family, the community and 'global society'. The person is seen as comprising biopsychosociocultural dimensions. 12 domains (of culture) used to inform understanding and identification of specific cultural issues across and between cultural groups; Overview/heritage (e.g. country of origin, education / occupation), Communication (Linguistic competence and other verbal/non-verbal means of communicating), Family roles and organisation (marital status and attitudes to gender and ageing), Work-force issues (autonomy and assimilation in relation to local practices), Bicultural ecology (physical ethnic issues, hereditary traits, epidemiology), High risk behaviours (culturally specific practices), Nutrition (rituals, choices and practice in relation to food), Pregnancy and child bearing practices (fertility, gender roles, pregnancy and childbirth) Death rituals (attitudes/behaviours related to death, dying and end of life care), Spirituality (ceremonies and practices), Healthcare practices (attitudes, beliefs and perspectives on own healthcare), Healthcare practitioners (attitudes, beliefs, perspectives on receiving care)

Appendix 2: Prisma Flow Diagram



Appendix 3: Included and Excluded Papers (literature review)

INCLUDED PAPERS						
	Author/Date, title, journal	**Aim of study**	**Type of study (design, methods of data collection and analysis)**	**Study findings**	**Strengths/ limitations of study**	**(A) factors specific to NQNs and CCPB (B) characteristics of skills/behaviours**
1	Hagman LW (2007); How New Mexico licensed registered nurses gained cultural self-efficacy and their stories. Journal of Cultural Diversity Winter 14(4): 183-191. US	How did New Mexico Nurses obtain the reported level of cultural self-efficacy?"	Exploratory, qualitative study of 66 participants (nurses) Text based responses to two open-ended generated from a larger survey of 398 participants. Ethnograph used to analyse qualitative data – content analysis	Key themes: on the job training, work experience, practicing as a nurse, life experience. Communication skills included asking questions, listening, observing, taking an interest Importance of education for RN's	<u>Strengths</u>; Software used to enhance coding Differentiates between years of qualification / experience <u>Limitations</u>; no demographic data reported on study sample. Limited information on analysis	(A) Length of years in practice [Novice versus experienced nurse] (A) Education and further training [CCPB as lifelong learning] (A/B) Knowledge as list of cultural facts insufficient to deliver CCPB (A/B) Skill development via interaction (B) Skills <u>Communication</u> (i) dissonance between patients' and nurses' interpretation of communication event (ii) language barriers
2	Lampley TM; Little KE; Beck-Little R; Xu Y (2008) Cultural competence of North Carolina nurses: a journey from novice to expert. Home Health Care Management & Practice, Oct 20(6): 454-461 US	Self-reported cultural competence of nurses'	Cross sectional survey design Convenience sample of 71 RN's in North Carolina. (Post-reg students, or employed in education or practice) Background Variables Data Sheet (BVS), 8 item demographic survey developed by research team. Qualitative data and the IAPCC. Analysis; requency of distributions, one-way ANOVA and independent samples *t* test. Out of the 71 completed surveys, 66 (93%) were usable and included in the data analysis.	IAPCC scores ranged from 39 to 72 (mean 53.05, *SD* = 6.26) group at level of cultural awareness (congruent with Benner's advanced beginner stage) 10 (15.2%) scored at the level of Cultural competence, 1 (1.5%) at culturally incompetent level. None scored culturally proficient. Neither race nor gender appeared had significant influence. Significant differences between the years of nursing experience and mean score of the IAPCC, $F(4, 61) = 3.478$, $p = .013$). Participants with 1 to 5 years of experience (*M* = 50.47, *SD* = 6.06) and those	<u>Strengths:</u> interrater reliability of 95% (2 researchers) in a trial analysis of 10 of 20 surveys. Range of demographic variables captured Linked with Benner's model <u>Limitations</u>: all participants pre-selected via convenience sampling. Small sample size, no control, one location limiting generalisability.	A) Length of years in practice [Novice versus experienced nurse] A) Need for further education and, or training [CCPB as lifelong learning] A) Knowledge of religious beliefs / difference health beliefs and behaviours A) Educational level B) Skills <u>Communication</u> (i) language barriers (ii) culturally inappropriate non-verbal communication

				with more than 20 years (*M* = 57.11, *SD* = 6.50). Mean IAPCC scores of participants receiving continuing education significantly higher (*M* = 54.43, *SD* = 6.00) than those who did not (*M* = 50.63, *SD* = 6.09).		
3	Songwathana P and Siriphan S (2015) Thai Nurses' Cultural Competency in Caring for Clients Living in a Multicultural Setting Pacific Rim Int J Nurs Res; 19(1) 19-31 Thailand	To assess level of Thai nurses' cultural competency in caring for clients living in a multicultural setting	Descriptive survey used self-report questionnaire on Cultural competency (SRCC) (used Campinha-Bacote's. 5 dimensions. 126 newly registered nurses in public hospital, district hospital or primary health care centre in 3 provinces in Thailand. Power calculation (5% of 3,000), stratified random sampling, 150 required (70% response rate) Demographic data (age, sex, religion, place of living, work experience and health care service, training about multicultural care, colleagues with a different culture, language in daily communication, experience in caring for multicultural patients) Knowledge dimension tested for internal consistency using Kruder-Richardson (KR- 20), yielding a value of 0.72. Other 4 tested using Cronbach's alpha coefficients, yielding a total value of 0.84.	Nurses' overall level of cultural competency was moderate. Cultural awareness, encounters and desire were at a high level. Cultural knowledge and skill were at a moderate level. No significant differences were found according to period of working, health-care setting or training experience about multicultural care, but differences were found across religion (p<.05). Skills – highest scoring items were listening to others and assessing ideas, beliefs and values of clients (= 3.28, SD = .776, = 3.01, SD = .701 respectively). 65.1% had no previous training	Strengths SRCC was pilot-tested on 30 nurses and specifically examines those within 1 year of qualification stratified random sampling, 70% response rate Weaknesses – majority 118 had been qualified a year, No comparator group, Location and context – Study participants were from the three southernmost provinces of Thailand – not representative or generalizable	(A) Only looked at Novice (A) Did not explore need for further education – (A) Cultural knowledge at moderate level (ethnic differences and communication challenges) (B) Skills Listening, assessing ideas, beliefs and values of clients [cultural assessment]
4	Jirwe M; Gerrish	To identify the knowledge,	A Delphi survey.	A total of 118 out of 137	Strengths: included skills	Core domains identified; cultural sensitivity,

	K; Keeney S; Emami A (2009) Identifying the core components of cultural competence: findings from a Delphi study.; Journal of Clinical Nursing, Sep 18(18): 2622-2634. Sweden	skills and attitudes that form components of cultural competence.	Purposeful sample of 24 experts (eight nurses, eight researchers and eight lecturers) Interviews then content analysis – into stage 1 (of 4) questionnaire using Likert statements using 7 point scale; 'not at all important' (1) to 'very important' (7).	components reached a consensus level of 75%. These were coded to 5 areas with 17 associated subcategories Skills/behaviour focused on communication and language. Ethnographic history and challenging racism not seen as impt	focus and sought range of views. High response rate and on-going involvement indicate valid findings. Considers social and cultural context and how applies to patient during hospital stay <u>Limitations:</u> Small study sample, one location, and not representative of the RN population Did not consider NQNs, did not seek patient perspective, no demographic details of the sample, no between group analysis Used existing framework of core domains to frame findings	understanding, cultural encounters, understanding of health, ill-health and healthcare and social and cultural contexts consistent with other evidence B) Skills <u>Communication</u> (i) awareness of factors impacting on cultural encounters (ii) interpersonal skills required to establish an effective encounter (iii) language and communication skills
5	Cai DY (2016) A concept analysis of cultural competence, International Journal of Nursing Sciences , 3, 368-273	To clarify the meaning and reduce ambiguities of the concept cultural competence, and promote consistency in using the concept in nursing dialogue	Used Walker and Avant's method of concept analysis.	Antecedents were cultural diversity, cultural encounter, and cultural desire. Cultural Competence (awareness, sensitivity, knowledge and skill) Consequences involve three beneficiaries, as follows: clients, nurses, and healthcare organisations.	<u>Strengths</u>: Multi-component model (inclusive of patient outcomes and organisational context) <u>Weaknesses</u>: No detail of the concept mapping process, 45 papers included but only 37 in reference list	B) Skills <u>Cultural Assessment</u> (i) collection of relevant data (ii) incorporating relevant data ii) availability of culturally appropriate resources to plan and provide care <u>Communication</u> (i) verbal and non-verbal skills required to undertake cultural assessment (ii) (appropriate) use of interpreters (iii) language and communication skills
6	Campinha-Bacote (2011) Delivering Patient Centred Care in the Midst of cultural conflict: The Role of Cultural Competence, OJIN (On-line Journal of Issues in Nursing), 16 (2) Manuscript 5	To provide nurses with a set of culturally competent skills that will enhance the delivery of patient-centered care in the midst of a cultural conflict.	Discussion paper using vignette of a parent (Mrs. Lee Southeast Asian woman) who brings daughter (Leah age 2) into the emergency room for treatment and care	Cultural competence is viewed as an expansion of patient-centered care Vignette highlights skills in relation to cultural assessment (cultural skill) during interaction with patient (cultural encounter) –	<u>Strengths:</u> Use of patient vignette to describe the application of CCP**B** in practice to illustrate key skills. An exemplar. Weaknesses One vignette, entirely descriptive	(B) <u>Skills</u> (i) undertaking a cultural assessment <u>Communication</u> (i) communicating respect and compassion (i) cultural negotiation

	US			demonstrating respect and compassion for the cultural belief of patient through communication (culturally skill) negotiating a mutually acceptable treatment plan (cultural skill) A cultural encounter is the act of directly interacting with patients from culturally diverse backgrounds During the cultural encounter is it also important for the nurse's values to be respected.		
7	Horvat Lidia, Horey Dell, Romios Panayiota, Kis-Rigo John (2014) Cultural competence education for health professionals. Cochrane Database of Systematic Reviews, Issue 5. DOI: 10.1002/14651858.CD009405.pub2. systematic Review)	To assess the effects of cultural competence education interventions for health professionals on patient-related outcomes, health professional outcomes, and healthcare organisation outcomes.	Standard Cochrane review methodology – quality of evidence low across all outcome criteria; evaluations of care (3 studies), Involvement in care (1 study) Health professionals knowledge & understanding (1 study), Health behaviours (1 study), Treatment outcomes (2 studies)	Health professionals knowledge and understanding (Awareness of racial differences) - No evidence of effect on clinician awareness of racial differences in the quality of diabetes care for Afro-American clients (1 study) found. Proportion of clinicians acknowledging racial disparities in care occurred very often or somewhat often ten (RR 1.37, 95% CI 0.97 to 1.94). Intervention can teach interpersonal skills (e.g. advanced communication negotiation, collaboration) linked to trust and partnership establishment or intra-personal skills (cultural self-assessment, reflective practice, deconstructing stereotypes).	<u>Strengths of review:</u> extensive range of database searching (with no date parameters to capture all evidence). <u>Weaknesses:</u> Review compromised by the fact limited number of papers met review criteria rather than review itself (due to lack of consistency in specifying knowledge, interventions teaching and learning, absent standards and measures for implementation and poor quality studies)	B) Skills (i) inter- and intra-personal skills (ii) Cultural self-assessment (iii) Communication (verbal and non-verbal), (iv) collaboration (v) Deconstructing stereotypes (vi) Trust and partnership establishment

	Author/Date, title, journal **Excluded Papers**	Rationale for exclusion
1	Vasiliou M, Kouta, C and Raftopoulos V (2013) The Use of the Cultural Competence Assessment Tool (Ccatool) In Community Nurses: The Pilot Study and Test-Retest Reliability. International Journal of Caring Sciences, Jan-Apr 6(1): 44-52.	Excluded. Has age data for the sample but not years since qualified. Testing of Ccatool not behaviour, skills or competencies
2	Mortensen A (2010); Cultural safety: does the theory work in practice for culturally and linguistically diverse groups? Nursing Praxis in New Zealand, 26(3): 6-16.	Excluded – discussion paper rather than primary research
3	Doutrich D; Storey M (2004); Education and practice: dynamic partners for improving cultural competence in public health. Family & Community Health, Oct-Dec 27(4): 298-307.	Excluded – relates specifically to student nurses
4	Jeffreys, MR and Zoucha, R (2017) The invisible culture of the multiracial, multiethnic individual: a transcultural imperative (reprint from 2001). Journal of Cultural Diversity, 24 (1) 6-10	Excluded – discussion paper focused on patients not nurses, not skills not behaviours.
5	Lange, Jean W.; Mager, Diana R.; Andrews, Nancy (2013); The ELDER expansion project: building cultural competence among long term home care workers. Applied Nursing Research, May 26(2): 58-62.	Excluded evaluating raising staff awareness about health beliefs and patterns among varied cultures, not skills not behaviour
6	Chang HY; Yang YM Kuo YL (2013) Cultural sensitivity and related factors among community health nurses. The Journal Of Nursing Research: 21 (1), 67-73.	Excluded focus on cultural sensitivity and demographic characteristics not skills not behaviour
7	Campbell-Heider N; Rejman KP; Austin-Ketch T; Sackett K; Feeley TH; Wilk NC (2006) Measuring cultural competence in a family nurse practitioner curriculum, Journal of Multicultural Nursing and Health, 12 (3), 24-34	Excluded – focused on curriculum development not skills, not behaviour.
8	Canales MK; Bowers BJ (2001) Expanding conceptualizations of culturally competent care. Journal of Advanced Nursing 36(1): 102-111	Excluded – focused on nurse educators (not in practice, not skills or behaviours)
9	Saccomano SJ and Abbetiello GA (2014) Cultural Considerations at end of life care. Nurse Practitioner, 39 (2) 24-32	Excluded – not NQNs, not skills or behaviours
10	Doutrich D; Storey M (2006) Cultural competence and organizational change: lasting results of an institutional linkage. Home Health Care Management & Practice, Aug 18(5): 356-360.	Excluded – development of training materials and Public Health orientation module, not skills or behaviours
11	Doutrich D; Arcus K, Dekker L, Spuck J and Pollock-Robinson C (2012) Cultural safety in New Zealand and the United States: looking at a way forward together. Journal Of Transcultural Nursing [J Transcult Nurs] Apr; Vol. 23 (2), 143-50.	Excluded – cultural safety, cultural awarenesss not skills or behaviour
12	Kozub LM (2013) Through the Eyes of the Other Using Event Analysis to build Cultural Competence Journal of Transcultural Nursing, 24 (3) 313-318.	Excluded – no details on the sample provided. Set in classroom context - student nurses not NQNs, not behaviour not skills
13	Liu L; Mao C; Barnes-Willis LEA (2008); Cultural self-efficacy of graduating baccalaureate nursing students in a state funded university in the Silicon Valley. Journal of Cultural Diversity, Fall 15(3): 100-107.	Excluded – not focused on NQNs – student nurses
14	Delgado DA, Ness S, Ferguson K, Engstrom PL, Gannon TM, Gillett C (2013) Cultural Competence Training for clinical staff measuring the effect of a one-hour class on cultural competence, Journal of Transcultural Nursing, 24 (2) 204-213	Excluded – measuring pre and post training scores, not skills, not behaviours
15	Foronda C, Baptiste DL, Reinholdt MM and Ousman K (2015) Cultural Humility A Concept Analysis, Journal of Transcultural Nursing, 27 (3) 210-217	Excluded: not NQNs not primary study, not skills or behaviour
16	Agbedia CO (2008) Transcultural nursing: insight and perspectives. West African Journal of Nursing, 19(1): 33-38. 6p.	Excluded – discussion paper on cultural competence, Students and the curriculum
17	Hemberg JA; Vilander S (2017); Cultural and communicative competence in the caring relationship with patients from another culture. Scandinavian Journal Of Caring Sciences Feb 24.	Excluded – ages / length of time qualified not provided – working abroad ./ work experiences NQNs not skills, behaviour, language concordant care.
18	G. Taylor I. Papadopoulos, V. Dudau M. Maerten, A. Peltegova & M. Ziegler (2011) Intercultural education of nurses and health professionals in Europe (IENE). International Nursing Review, 188-195, International Council of Nurses	Excluded – combined sample of students and qualified practitioners (118) no information about skills, competencies or behaviours
19	Nerfis SE (2015) Developing and implementing a cultural awareness workshop for nurse practitioners. Journal of Cultural Diversity, Fall, 22(3): 105-113.	Excluded; goal of study was to increase participants' level of knowledge, not skills not behaviour.
20	Spence DG (2001) Prejudice, paradox, and possibility: nursing people from cultures other than one's own. Journal of Transcultural Nursing, Apr 12(2): 100-106	Excluded - No details provided in the study paper as to the sample characterisitic – unable to determine whether NQNs or not, nor length of time since qualification. Not behaviour not skills

21	Kim-Godwin YS, Clarke PN and Barton L (2001) A model for the delivery of culturally competent community care Journal of Advanced Nursing, 35(6), 918 – 925	Excluded - Insufficient detail provided on either sample, concept analysis or the development of the model or Cultural Competency scale (CSS) for inclusion. Not behaviour or skills.
22	Harmsen H, Bernsen R, Meeuwesen L, Thomas S, Dorrenboom G, Pinto D, et al (2005). The effect of educational intervention on intercultural communication: results of a randomised controlled trial. *British Journal of General Practice* 55 (514), 343–50.	Excluded – no information on intercultural communication element of the intervention
23	Majumdar B, Browne G, Roberts J, Carpio B (2004). Effects of cultural sensitivity training on health care provider attitudes and patient outcomes. *Journal of Nursing Scholarship* 2004; 36(2):161–6.	Excluded - effectiveness of cultural sensitivity training on the knowledge/ attitudes of health care providers, and to assess the satisfaction and health outcomes of patients from different minority groups with health care providers who received training
24	Sequist TD, Fitzmaurice GM, Marshall R, Shaykevich S, Marston A, Safran DG, et al (2010). Cultural competency training and performance reports to improve diabetes care for black patients: a cluster randomized, controlled trial. *Annals of Internal Medicine*;152 (1) :40–6.	Excluded – did not report upon communication or skills only Clinician awareness of racial differences in diabetes care
25	Thom DH, Tirado MD, Woon TL, McBride MR (2006). Development and evaluation of a cultural competency training curriculum. *BMC Medical Education* 2006; **6** :38.	Excluded – reported on change in the Patient-Reported Physician Cultural Competence (PRPCC) score post cultural competency training but did not describe the training, invention or skills
26	Hagman LH (2006) Cultural Self-Efficacy of Licenced Registered Nurses in New Mexico. Journal of Cultural Diversity, 13(2) 105-112	Excluded – scores reported on Cultural Self Efficacy Scale but not by number of years as RN. No information on behaviour, skills or competencies

Appendix 4: Data collection tools (directed reflection and interview topic guide)

Introduction to Guided Reflection

This guided reflection will assist you to reflect upon your practice and how you engage with, care for and support patients from diverse backgrounds. You are asked to complete this on two occasions; two-three months into your first post and again at five-six months. On each occasion you will be contacted via email and the template provided for you. If you would prefer to have this in a hard copy format you will be sent this through the mail.

The template is structured and each part asks you to think about and record your reflections, thoughts and views about a recent practice experience. There are no right or wrong answers and you can choose what to write in each section. The questions are merely to guide you. Reflecting on your practice in this way gives you an opportunity to take some 'time-out' and contemplate how you engage with, care for and support patients from diverse backgrounds. You may also wish to use this in clinical supervision or during discussions with your preceptor.

Please be careful when you are describing specific situations that you do not provide names or other details that might identify a patient or colleague. Just as your confidentiality in protected in this study, it is important that you protect that of your patients and colleagues.

The reflective template

Think about a recent experience in practice in which you cared for someone who you would describe as different to you, or culturally diverse.

Instruction 1: Describe the patient and situation in which you were interacting

Instruction 2: Describe how you cared for the patient and what you did as a nurse to respond to their diversity and cultural needs (what did you do? what did they do?)

Instruction 3: Describe your thoughts and feelings about this particular experience (how did you feel before, during and after this event? what did you learn about yourself? what did you learn about the patient?)

Instruction 4: Explain why you think it was important to deliver care in this way and what were the benefits to the patient and to you.

Would you like to add any other comments or thoughts about this particular experience?

Interview Topic Guide

Introduction to the interview

The introduction to the interview will cover the following key issues;

1. A thank you to participants for agreeing to be interviewed
2. Re-statement of participant confidentiality and rights (including right to withdraw, pause or stop the interview)
3. Reminder that the interview will be recorded
4. Reminder that this is not an examination or assessment of performance – it is an opportunity to reflect and inform best practice

Proposed interview topic areas and questions:

Member checking of journal entries

The first part of the interview will be linked exclusively to the journal entries. These questions will be focused on;

- Clarifying jargon, abbreviations
- Clarifying terms or descriptions
- Seeking expansion of ideas and examples provided

Topic 1: Experience of caring for culturally diverse patients

  - What experiences have you had experience of caring for culturally diverse patients during your period of employment?
  - Could you give me an example of caring for a patient who could be described as culturally diverse under the current quality legislation? Additional prompts i.e. age, disability, sex, gender reassignment, pregnancy and maternity, race, religion or belief and sexual orientation
- What have these experiences been like for you?
- Do you feel confident caring for culturally diverse patients?
- What do you think are the main benefits to patients in being cared for by a practitioner who is culturally competent?

Topic 2: Skills and competencies

- What key skills and competences do you think you have developed in relation to cultural competence during this time?
- What key skills do you think you still need to develop?
- How do you plan to further develop your skills in this area?

Topic 3: Enablers

- What do you think has helped you as a practitioner to practice in a culturally competent way during this time?
    - Prompts - Personal factors (personal experience of diversity, self, family, friends)
    - Prompts - Organisational factors (support of mentor/preceptor, supervision, workplace culture)

Topic 4: Limiters

- What do you think might have prevented or limited you as a practitioner to practice in a culturally competent way?
    - Prompts - Personal factors (personal experience of diversity, self, family, friends)
    - Prompts - Organisational factors (support of mentor/preceptor, supervision, workplace culture)

Interview closure

Closing question: Is there anything else you would like to add about your experiences of caring for culturally diverse patients?

The interview will be terminated with the following:

1. A thank you to participants for being interviewed
2. Re-statement of participant confidentiality and rights

Sources of support in the event of participant becoming distressed

Participants will be advised to access counselling support or mental health services via their own G.P., through the Occupational Health Services via their employer or self-refer if preferred. Counselling support is available nationally through the current IAPT programme (Improving Access to Psychological Therapies) and there are points of contact for each locality. Alternatively if participants are members of a professional union (e.g. The RCN, RCM, Unison, CPHVA/Unite) they will be advised to access member support services which provide free, confidential support and assistance to help members deal with any challenging emotional issues that they may face. Information will be provided as follows:

IAPT Services and Support via http://www.iapt.nhs.uk/
Royal College of Nursing (RCN) 0345 772 6100
Royal College of Midwives (RCM) 020 7312 3535
UNISON 0845 355 0845
CPHVA/Unite 020 7611 2500

Appendix 5: Invitation email, study information sheet and consent form

Volunteers wanted!

Are you a nurse who has recently graduated?

Would you like to take part in a study that is looking at cultural competence and the experiences of newly qualified nurses?

Yes!

If you would you like to take part in this study you will be asked to provide some information about your experiences as a newly qualified nurse during your first 7-8 months following qualification. If you would like you can receive a detailed report on your cultural competence at the start and end of your involvement in the study so that you can see how you have developed.

If you would like to volunteer for this study find out more by contacting Jane Wray on jwray@student.bradford.ac.uk or 07545 052315 (mobile).

Study information sheet

Dear Participant

This information sheet is to tell you about some research being undertaken by Jane Wray as part of a PhD in the School of Health Studies, University of Bradford. Should you agree to take part, all information that you give to us will be treated in the strictest confidence.

Invitation

You are being invited to take part in a research project. Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information and discuss it with others, Jane Wray or her supervisors if you wish. If there is anything that you don't understand, or if you would like further information, please contact Jane or her supervisors (see contact details below). Thank you for taking time to read this. If you would like this information sheet in an alternative format, please contact Jane.

What is the purpose of the Study?

The purpose of this study is to explore the culturally competent practice behaviours of newly qualified nurses during the first 7-8 months of professional practice. The study will look at how newly qualified nurses understand and explain their practice behaviour when engaging with patients who are diverse or culturally different to them as they transition from student to fully accountable practitioner.

Why have I been chosen?

You have been chosen to take part because you are in the final year of your pre-registration nursing programme and about to qualify as a registered nurse.

Do I have to take part?

The decision to take part is entirely voluntary; if you do not wish to take part this will not affect your current studies or your future professional practice. If you agree to take part and then, during the course of the project you change your mind, you can withdraw at any time by contacting Jane (see contact details below). Any data collected up to that point will be destroyed and will not be used in any results.

What is expected of me?

You will be asked to undertake a number of activities during a period of 7-8 months. During the project, information will be collected from you at four points in time; at the point of registration with the NMC, at 2-3 months, 5-6 months and at 7-8 months. After you have completed your consent form you will be given the opportunity to complete the Intercultural Development Inventory (IDI) an on-line tool that measures cultural competence. Completion of the IDI will take approximately 20-25 minutes and you will receive a copy of your IDI report. At 2-3 months and at 5-6 months you will be asked to complete a short diary template to provide a reflective piece about your practice. You will be given guidance on how to complete this and you will be sent the template to complete via email (or post depending on your preference). This should take about half an hour to complete each time. At six to seven months you will be interviewed over the telephone, Skype, or FaceTime (again depending on your preferred option) for 30-40 minutes to discuss your experiences further and talk about the reflective pieces you have provided. The purpose of this interview is to ensure that the researcher has fully understood what you have written. All interviews will be recorded. You will also complete the on-line IDI again and receive your second feedback report. The total time you will be expected to contribute to this project over this 7-8 month period will be two and a half hours (maximum). If you wish you can also receive copies of the executive summary of the study and any publications.

Are there any benefits to being involved?

You will receive your personalised IDI reports at the start and end of your involvement in the project. These reports will provide you with detailed information about your cultural competence and your personal and professional development during this period of time. You will be asked about your IDI reports during the interview but the full reports will remain entirely confidential to you and the IDI administrator only and will not be used in the study.

Will my taking part in this study be kept confidential?

The responses you make will be treated in the strictest confidence, no one but Jane Wray and her supervisors Professor Uduak Archibong and Dr Sean Walton will have access to the information you provide. You will be asked to provide your contact details (phone, email, address) and you can choose whether you provide any additional personal details (age, gender, ethnicity, religion, sexuality, disability). Your personal details or any other information that you provide will not be made public in any way that could reveal your identity to a third party. This will include in the thesis, presentations or any published papers.

What will happen to the results of the research study?

The results of the study will be used to complete a PhD thesis. Aggregated results will be reported in the thesis and in academic and professional journals

and during conference proceedings. All information collected from you will be kept on a password protected computer for one year following submission of the PhD thesis. This information will then be placed in a designated data storage facility in the Faculty of Health and Social Care (FHSC) at the University of Hull for a further five years before being destroyed.

Who is organising and funding the study?

The study is being organised by Jane Wray, a PhD student in the School of Health at the University of Bradford. The project is not funded but is part of a PhD study. Ethical approval to proceed has been given by the Humanities, Social and Health Sciences Research Ethics Panel at the University of Bradford on 24th October 2014.

Contact details

If you have any queries, would like to discuss this further or would like any additional information, please contact Jane Wray via email jwray@student.bradford.ac.uk, or phone 07545 052315 (mobile) or Skype janewray1. If you wish you can also discuss this with her PhD supervisors Professor Uduak Archibong on 01274 236347 or Dr Sean Walton on 01274 235127.

Yours faithfully

Jane Wray, PhD Student, School of Health Studies, University of Bradford, Bradford BD7 1DP

Culturally Competent Practice Behaviour and the transition of new registrants in nursing

CONSENT FORM

Jane Wray will have contacted you to discuss the above project. Thank you for agreeing to be involved in this project and for contributing your views. You are asked to sign this form to show that you understand the nature of the project and what is expected of you so that you provide your consent to participate.

All information will be confidential to the principal researcher (Jane Wray) and her supervisors Professor Uduak Archibong and Dr Sean Walton. However if you provide information that may place you or others at risk of harm, or contravenes the Nursing and Midwifery Council's (2008) Code: Standards of conduct, performance and ethics for nurses and midwives then our professional duty obliges us that this information be shared with the relevant person or body. You will be informed if this is the case.

Your anonymity will be protected in any reports, publications and, or presentations following completion of the project. This means that your personal details or any other information that might reveal your identity will not be included in any published material. You are free to withdraw from the research at any time (including during the taped interview) and any data collected up to that point will be destroyed and not used in any results.

"I agree to participate in this study, the nature of which has been explained to me by Jane Wray. I understand that signing this form does not affect my right to withdraw from the study at any time."

Name……

Date……

Signature……

I have explained the nature of the study.

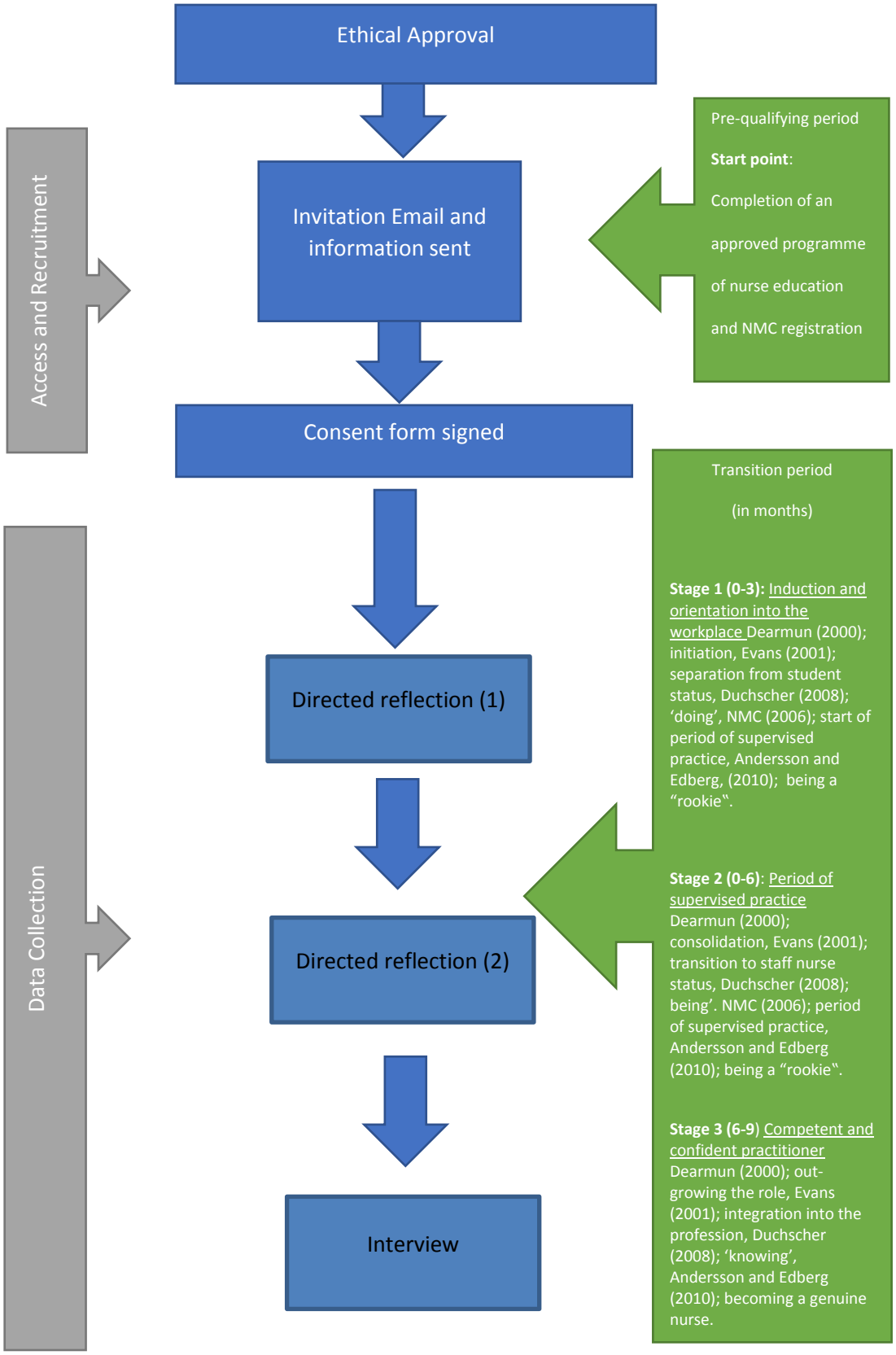
Name……

Position/role……

Date……

Signature……

Appendix 6: Study procedure flowchart and timeline



Appendix 7: Example of an individual transition story

Diversity or equality specific	Clinical details / nursing care	Perceptions / Feelings	Key points	Descriptions of behaviour
REFLECTIVE TEMPLATE 1				
woman Jehovah's Witness 1st exposure to patient who is Jehovah's witness I had never seen one (advanced directive card) before Policy/procedure in place we had a procedure in place to sort this kind of thing Importance of 'knowing' – you can plan care in relation to diversity specific issues I think you need to make sure that you know when someone is a Jehovah's Witness so you know what to do if you know in advance then you can read the policy so that the patient feels comfortable and not stressed about it. Respecting beliefs vs own views on the issue It about respecting people's religious beliefs even if they seem a bit strange to you	admitted with abdominal pain via A&E (possible ruptured appendix She was in pain and had a temp (38.5). She had had some pain relief in A&E just before transferring to the ward but still looked restless in case she would need prepping for theatre she didn't have a ruptured appendix but it was inflamed with a possible infection Communication so I checked that she was ok and got her settled comfortably in bed I checked this with the patient, I told her that she could have more pain relief soon and the Doctor was on his way with the scan records	Recognising own limitation and need to seek further advice, has some background knowledge but is limited As I didn't know much about Jehovah's witnesses other than that they refuse blood transfusions I thought I would better check what I should do Lack of knowledge = panic when confronting patient Initially I was panicking as I thought that she might have to go down to theatre and that she would refuse a blood transfusion and that is quite dangerous Lack of knowledge = erroneous belief that this religious position is 'dangerous' Not knowing when in front of patient = makes you feel 'stupid' (do not wish to appear incompetent) I felt a bit stupid because she asked me to copy it and return it to her as I was just staring at it I think just deciding what to do for the best Asking questions = finding answers I am glad I asked for help as I didn't know that. Recognises the need to learn by 'observing others' I wish I had asked to go with X (name removed) to see what she said to the patient but I had to go sort another admission	Lack of knowledge about religion and the impact of this on care delivery Lack of knowledge impact on knowing what to do - Anxious / nervous 'feel stupid' Seeking advice and guidance from others once I have spoken to the ward sister I felt better as she told me not to panic <u>OTHER NOTES</u> Senior nurse appears to recognise the challenge for NQN - I had a quick read but she said she would speak to the patient as it was complex. Clarify in interview – What is meant by the term serious' JW	Communication With patient -so I checked that she was ok and got her settled comfortably in bed Communication with colleagues – asking questions, seeking advice Clinical activities – getting patients comfortable, pain relief, preparation for theatre an advanced directive card
REFLECTIVE TEMPLATE 2				
gay man his sexuality not relevant to the direct patient care being given	reconstructive ACL on his knee I was caring for him post-surgery	Considers the potential for discomfort – other patients as well as patient himself	Making assumptions about the patient – what they are comfortable/not comfortable with	Post-surgery observations Protecting privacy

(at that point in time) In terms of him being gay I don't think I did anything that was different to what I would usually do for a patient who'd had this op. I just cared for him as I usually would The fact that he was gay wasn't that important to what I was doing. I just got on with the care as I would for anyone. Protecting privacy / ensuring confidentiality I thought it would protect his privacy and also he might not want everyone to know he is gay	I was doing the obs and checking site for any bleeding and drain working ok I guessed I could have asked him personally whether this was what he wanted	I thought I would give him some privacy with his partner so that they didn't feel uncomfortable in front of the other patients. I didn't mind them holding hands or kissing but I thought the other patients might be a bit funny about it. I didn't want the other patients to feel uncomfortable or him or his partner	Diversity (sexuality) not relevant to some aspects of direct clinical care – but then becomes relevant? Personal views vs what 'other' patients might think Organisational context – environment may impact upon how you deliver care. Presence of other patients? I think you have to think about all the patients in the ward area (when it's a six bedded bay) I had to think about the other patients too <u>OTHER NOTES</u> Check ACL - ? **anterior cruciate ligament** so it seemed like the most sensible thing to do - Sensible? Clarify this	Protecting confidentiality Sexuality becomes relevant only difference was that when his partner arrived I made sure the curtains were drawn a little bit so that they wouldn't feel uncomfortable holding hands
INTERVIEW TRANSCRIPT				
1st exposure to a challenging diversity situation I had never come across one you see not before and those kinds of things stick in your mind. Insufficient knowledge + awareness of that lack = confusion / distress I mean if she won't have a blood transfusion so my mind was a bit all over the place - because well it just threw me. Practice area prepared for this although uncommon	Communication-communication – it really is the most important thing you do every day with everyone. you have to be a good communicator and I think that is something I have really picked up on working here yes Constantly interacting with different people = enhancing communication skills so you can't mess about you have got to get it right so that they understand what you need them to do Time pressure of environment means you have to make sure you communicate	1st exposure to a challenging diversity situation = confusion / panic? I had never seen anyone produce that kind of thing so I was a bit you know sort of confused I do know a bit more about it now because after that I made sure I learnt about it you know read the policy Patient beliefs vs Nurses beliefs even though well you don't agree with them and thinking they are like a bit homophobic and that they should just keep their opinions to themselves they are still your patients too <u>Motivation</u> for a diversity specific behaviour = compassion for the patient. I didn't want them to feel like awkward	<u>Experience, competence confidence</u> NQN – experience linked with increased competence but also keep learning. I do know a bit more about it now because after that I made sure I learnt about it you know read the policy Recognises the need to learn by 'observing others' I think that might have been good to do I think at the time yes because I could have seen how she dealt with it Language - phrasing 'a problem for her' rather than a problem for the nurse / staff	Communication – with patients and with colleagues Managing patient confidentiality and privacy yes I did try and give him and his partner a little bit of privacy <u>Intersection</u> of the delivery of clinical care with patient beliefs or diversity characteristics e.g. specific whether they need a special diet or something, maybe to use the prayer room or some special equipment or bed Responding to people's religious needs = equivalent consideration to meeting physical care needs?

we have a policy on this because although this doesn't happen very often it does happen and when you work in this area it might come up Better recognises that there are individual differences and diversity within a particular belief system I realised that it's not always straightforward you know because there are some blood products that they will have. And also you have to be quite careful about it because they might say that there are ok about it but they won't want the rest of the family to know because you know well that wouldn't be viewed well. So it does depends on them and what they are ok with I guess. Aware of a really important issue with patients who are JW – i.e. potential consequences of them choosing to have blood and the impact of that on the person / extended family. Recognises that there are individual differences within a specific religion (serious v non-serious) You know like some people say they are a particular kind of religion but they don't always follow everything to do with it so	effectively for the ward to be efficient Because it's always busy you just have to, you don't you think about it too much so it's really down to what do they need, get it and then get on with it. This is both diversity specific and about communication – diversity of communication experiences So one minute you are talking to an Asian man with the help of his wife or kids and the next it's an old lady with a hearing aid that doesn't work.	Personal experience sensitises you I might have been a little bit sensitive to that situation Transition and cultural diversity I think I am fairly confident about it. I mean I just try and get on with it Transition and communication I am definitely better at it then when I first started. (competence improves) Taking learning from others (brother, friends) = thinking about impact and then impacting on individual and how they practice I mean I'm not gay so I don't have that experience but with my brother and his boyfriends and their friends I have learnt a lot and I do think it's made me a better nurse because I try to think about things like that and be nice to everyone no matter who they are. I think you just have to learn as you go along picking up stuff and if you don't know then you find out. Transition experience – picking up as you go along At 9 months no longer NQN but the 'role model'? But I have been here for quite a while now so I am pretty familiar with how things are done and now some of newly qualified staff ask me about things. I think probably not I try to not judge people and get on and do my job. Nurses' feelings irrelevant to delivery of care / Intersection between your personal beliefs Vs other peoples' beliefs	my immediate concern was that this might be a problem for her and because I didn't know much about it at the Intersection between nursing care / clinical priorities and people's beliefs I so I just think if something will save your life and you need it then it doesn't make sense to me really that you wouldn't do it Irrespective of their background you still need to treat / care for them – no matter what you personally think? Personal / professional dichotomy here (NMC?) <u>Organisational constraints</u> Consideration of people's views must take into account all patients when you have a ward full you sometimes well you just have to think about that, because you have to think about all of them not just one Because it's always busy you just have to, you don't you think about it too much so it's really down to what do they need, get it and then get on with it. Support / role models / Seeks guidance from others in team I did in the end just go and ask someone, also I remember talking it through with X (name removed) as she dealt with it in the end	<u>Motivation</u> for a diversity specific behaviour = compassion for the patient. Also = consideration of potential impact on others (including self) Attitude? you just have a positive attitude really. Being non judgemental

yes I think I meant that she was someone who took their religion very seriously and followed all the rules and that (pause). Responding to patient diversity – providing privacy for people to express themselves in hospital yes I did try and give him and his partner a little bit of privacy Previous negative response from other patients informs (future) response / decisions - consideration of peoples diversity impacted by behaviour of others? Sometimes people can be funny can't they? with them being a gay couple and everything we have had some issues before with patients being uncomfortable and everything There was one in particular who was awful and he kicked off about it and was really quite offensive. Relevance of own background / history Well my brother well he is gay and well he has had people say horrible things to even beaten up a couple of times because people don't like him being gay Personal experience of		I mean that's how it is isn't when you are a nurse people have their beliefs and religions and things and you just have to deal with it even if it does seem strange to you Commitment of colleagues? Team working There are always staff, always, everywhere you work who just you know do the bare minimum and are off as soon as they can. Perception of NQN of preceptor – no time, was dumped on her, she didn't want to do it, = maybe she didn't like me / characteristics of poor preceptor = impacts on confidence of NQN I did have a supervisor at first, you know a preceptor but that didn't work out and they left anyway and so I was meant to get another one but it didn't happen. Didn't really have that much time for me. I think maybe I had been dumped on her and she didn't want to do it Maybe she didn't like me I don't really know but it was a bit rough on me when I first started and she was like I can't be bothered. NQN close to exiting due to poor experience - Positive role model changes the perception If it wasn't for X (name removed) I probably would have left myself but I was on lots of shifts with her so that she helped me out. Staff training It is a staff training thing about caring for people with learning disabilities.	Accounts for this by explaining herself as NQN I think I hadn't been qualified that long then Organisational support from colleagues = develop confidence and competence yes there are definitely some people here that have taught me a lot about patients, about how to care for them and how to do the job really I suppose. It's always busy and yeah sometimes people get stressed, things don't always good according to plan but that is how it goes sometimes. Organisational attitude interesting = its busy, things do go according to plan, but that is ok (learning organisation?) what you don't want is to be stuck in the middle of it all (pause). When conflict between patients occurs – nurse can get stuck in the middle	

diversity (or maybe discrimination) increases awareness When you have grown up with that and you see what it can be like for people it breaks your heart and yes it definitely makes you more aware of just what things can be like for people. Impacts on decision making? Exposure to diversity within healthcare settings can be limited or extensive (type of clinical setting can make a difference?) Definitely lots of different people in here all shapes and sizes, all ages all different backgrounds... We have a lot of Asian patients and well we see quite a lot of people who are from Poland and Eastern Europe so yes people from all different backgrounds really. Old people, young people I				

Other notes (from audio journal / field notes)

RT (1) really good example of how personal beliefs (religious orientation) intersects with clinical care delivery and the challenges that posed for the nurse. Obvious anxiety for NQN when faced with a 'novel' diversity situation – has insufficient knowledge / some assumptions regarding JW and this is reflected in words used 'panicking' 'feeling stupid' (related to how this made her feel – not necessarily the patient? – competence and confidence) link with reflection (reflection before, in and on)? Provides participant as an opportunity to reflect on an important moment in practice – there is little in the way of describing towards her patient – much more about herself? Passed onto a more senior colleague (who appears to recognise that this is complex and takes charge of the situation). Little in the way of discrete behavioural examples of responding to diversity in this.

RT (2). Chosen a gay man as an example – but clearly states that this wasn't relevant to the direct clinical care that was delivered as a consequence of surgery - except then it does become relevant in terms of respecting the privacy and confidentiality of the patient. Considers the complexity of this in more detail – patient, other patients, the ward environment (this links well with 'bigger picture' of understanding care delivery that comes with more experience / confidence / competence). Reflection perhaps less exclusively inward looking (as in RT1).

Interview – further detail provided on both RT1 and 2. The experience of being faced with a novel diversity situation (or maybe just a novel clinical experience) is remembered – impact of that experience of confusion, panic and distress when faced by patient and not sure what to do. Has learnt from this experience – definitely appears more

confidence in explaining it. During the interview it felt like the nurse wasn't particularly keen on this part of the discussion especially when I asked about terms previously used such as 'serious Jehovah's Witness' and 'strange' - perhaps she felt judged by me or uncomfortable by what she had previously said.

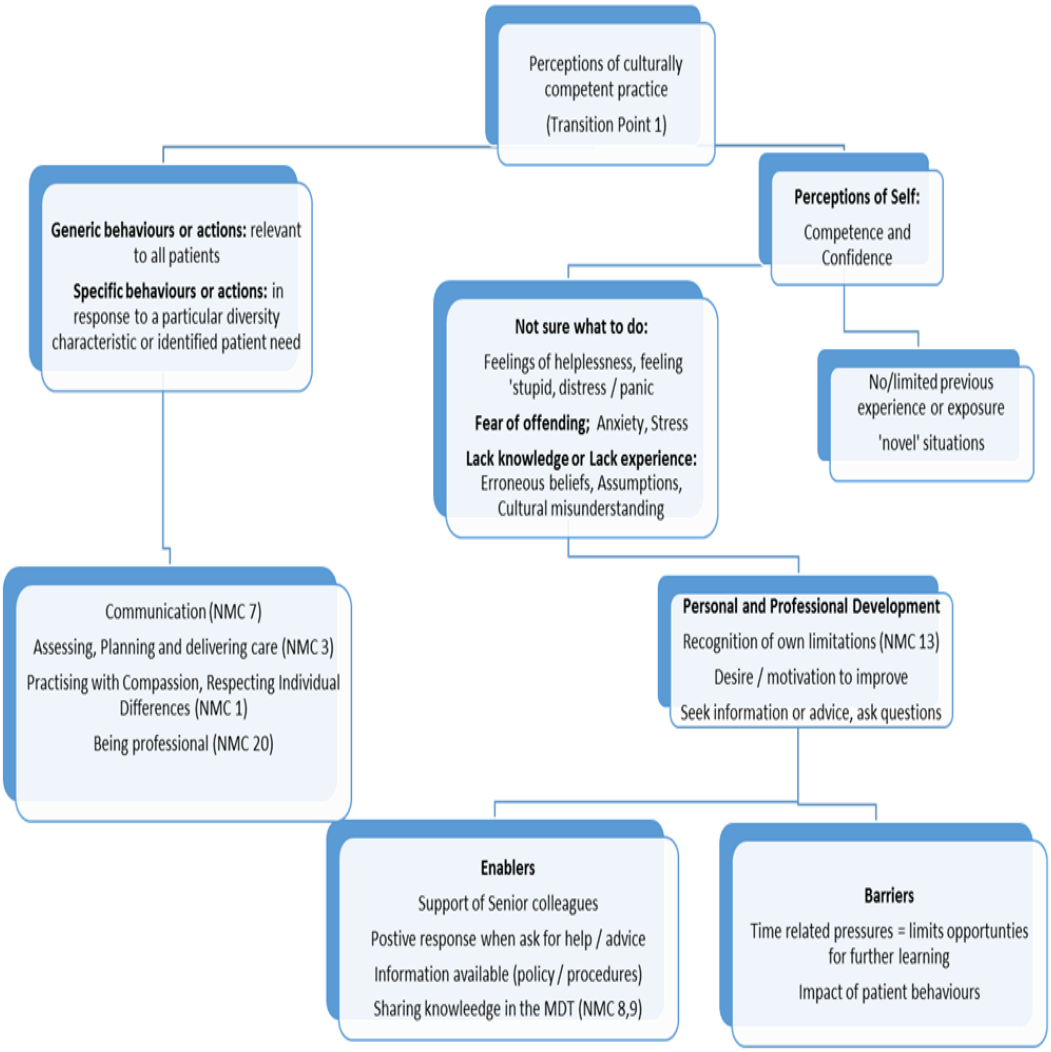
Definitely using different language now (professional socialisation?) and the example chosen for RT (2) became more clear when explaining about her brother. Seemed initially reluctant to share this but once did talked about impact of his experiences on her – her attitude / approach to patients (personal experience of diversity or even seeing first hand discrimination = impacts upon you).

Behavioural descriptors that do emerge focused on communication (although I might have led her into that one?) – But also privacy / confidentiality (both of which link with NMC Code – check this as possible framework from organising the themes and results). Consider the importance of how the delivery of direct nursing clinical care intersects with consideration of the patients specific needs related to their diversity. Judgement is made by the nurse as to when this is relevant perhaps? (Not exclusively a clinical judgement – mediated by personal experience?).

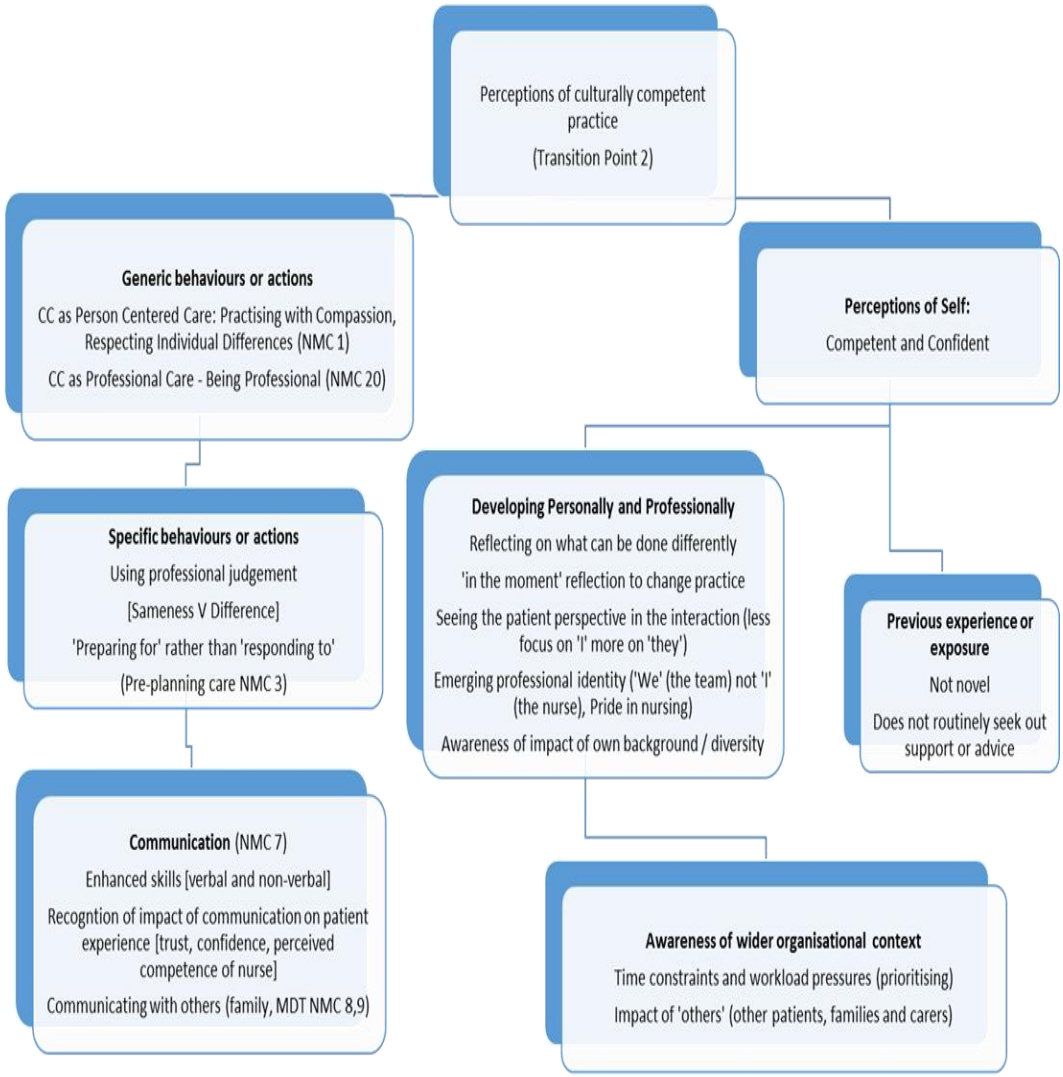
Comes across as much more confident in terms of nursing practice and has clearly incorporated the working norms of the setting (always busy but that's ok, got to be efficient means getting things done quickly but also got to get it right first time because you don't have time / capacity if you get in wrong!). Focus perhaps on patients understanding what they need to do (rather than nurses needing to understand the patient – this may relate to the looking inwards seen in RT1? – Although much less pronounced. Appeared to have a less than ideal preceptorship experience (xref with characteristics of poor preceptor) and this could have resulted in leaving the post – in contrast the positive support of a colleague (mentor / role model) mitigated against this.

Interview had to be re-scheduled (participant forgot and rearranged for the following day) – this may have affected responses to some questions there were also clear indicators that they wanted it over as quickly as possible! How many more questions / how long will it last. Disengagement with the research? The topic? Or just busy?

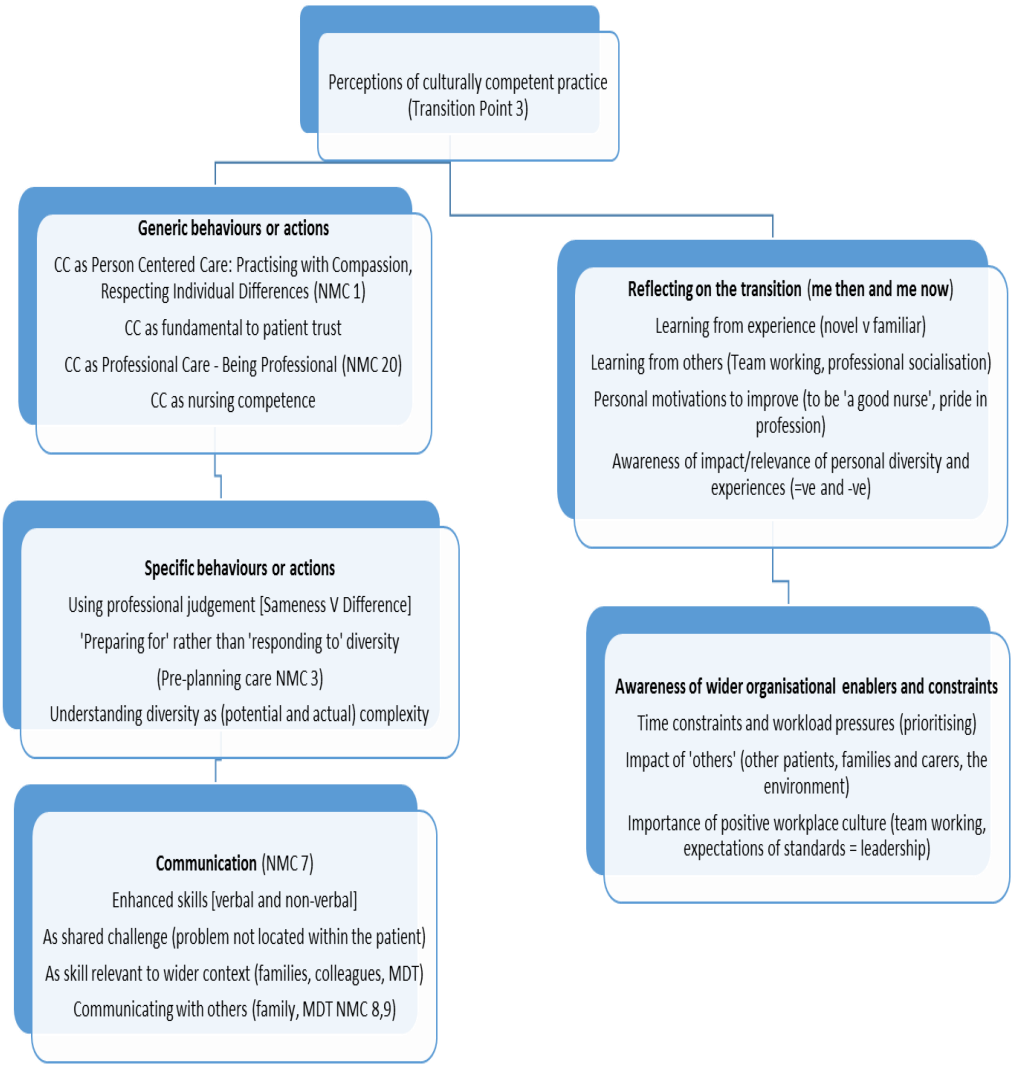
Appendix 8: Transition point 1



Appendix 9: Transition point 2



Appendix 10: Transition point 3



Appendix 11: Behavioural descriptors mapped against the NMC Code (2015)

Examples of CCPB provided by participants	NMC Code (2015) descriptors	Section of Code
Asking the patient questions to find out their particular needs or preferences	Practice effectively Prioritise people	7.3
Checking patient understanding during care delivery	Practice effectively	7.1, 7.4
Discussing care with patient and families to identify particular needs or preferences	Prioritise people	5.5
Discussing care with colleagues to inform their care delivery	Prioritise people Practice effectively	5.2 8.2 8.3
Asking permission to undertake intimate care	Not explicitly stated Implied in prioritise people	 5.1
Providing information in alternative formats	Not explicitly stated Implied in prioritise people	 7.2
Being non-judgemental	Prioritise people Promote Professionalism and Trust	1.3 20.1 20.2
Making reasonable adjustments	Not explicitly stated Implied in prioritise people	 7.2
Pre-planning care to meet the needs of diverse patients	Not explicitly stated Implied in Practice effectively – no specific section	
Putting yourself in patients shoes (empathy)	Not explicitly stated	
Being non-judgemental	Prioritise people Promote Professionalism and Trust	1.3 20.1 20.2

Communicating to reduce patient anxiety, promote trust	Not explicitly stated	
Communicating to ensure informed consent	Prioritise people	4.2
Communicating to enhance patient confidence	Not explicitly stated Implied in Promote Professionalism and Trust	
Using non-verbal communication (pointing, gestures, posture, eye contact,	Practice effectively	7.3
Asking the patient to speak slowly	Not explicitly stated Implicit in Practice effectively	7.1, 7.2
Using simple language (jargon free), rephrasing words	Prioritise people	7.1
Awareness of own feelings, behaviour, beliefs in relation to diversity	Prioritise people Promote Professionalism and Trust	1.3 20.3
Acknowledging anger and distress of others	Prioritise people	2.6
Being professional	Promote Professionalism and Trust	20.1 – 20.10
Kindness, Compassion	Prioritise people	1.1
Use of interpreters	Not explicitly stated Implied in Practice effectively	7.2
Allowing extra time for non-English speakers	Not explicitly stated Implied in Practice effectively	7.2
Allowing extra time for those with communication difficulties	Not explicitly stated Implied in Practice effectively	7.2
Being open with patients	Not explicitly stated Implied in Promote Professionalism and Trust	20.2

Recruitment strategy	Expression of interest	No. participated	Withdrawn	Attrition
Information placed on student VLE/email (HEI, 1, 2 and 3)	14	8	0	6
Presentation to student cohort (HEI 1 only)	7	4	1	2
Information via network (CHAIN, nursing forum.co.uk)	0	0	0	0
Word of mouth (via recruited participants)	4	2	2	0
Totals	25	14	3	8

Table 1: Overview of recruitment strategies

MSP Number	Interview Length in minutes
1	26
2	38
3	22
4	19
5	28
6	33
7	34
8	41
9	40
10	21
11	38
12	36
13	27
14	40
Average	31.64 minutes

Table 3: Telephone interviews (length in minutes)

Study Participant	DR1	DR2	Protected Characteristic
MSP 1	Elderly (87) Woman English	Women BAME (Eastern European)	Age, Ethnicity Gender
MSP 2	Woman BAME (Nigerian)	Woman White English	Ethnicity, Gender Socio-economic class
MSP 3	75 Year Old Asian Man	Elderly (75+) Male Disabled	Age , Ethnicity Gender, Disability
MSP 4	Chinese, Elderly Woman	Muslim Woman	Age, Ethnicity Religion, Gender Disability
MSP 5	Male Jewish	Disabled Man	Gender, Religion Disability
MSP 6	Male BAME (Syrian)	Homosexual Man	Ethnicity, Gender, Sexuality
MSP 7	Male BAME (Polish)	BAME (Kurdish) Man	Gender, Ethnicity
MSP 8	Child (age 7) Learning disability Female	Child (age 14) Muslim Female	Age, Ethnicity, Gender, Disability
MSP 9	Woman Jehovah's Witness	Homosexual Man	Age, Religion, Gender, Sexuality
MSP 10	Male Disabled	Female BAME	Gender, Disability Ethnicity
MSP 11	Female BAME (Eastern European)	Male Homosexual	Gender, Ethnicity Sexuality
MSP 12	Male Muslim	BAME (African) Man	Gender, Ethnicity Religion
MSP 13	Child (age 11) Female BAME	Child (age 9) Male Muslim	Age, Gender Ethnicity, Religion
MSP 14	Female Elderly BAME (Afro-Caribbean)	Female Chinese	Age, Gender Ethnicity

Table 4: Overview of diversity characteristics discussed by participants in reflective templates